MEETING THE NEEDS OF THE FRAIL ELDERLY

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN SERVICES

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MARCH 5, 1990, CLEARWATER, FL

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MEETING THE NEEDS OF THE FRAIL ELDERLY

MONDAY, MARCH 5, 1990

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HUMAN SERVICES,
Washington, DC

The subcommittee met, pursuant to notice, at 9:30 a.m. in the Community Hall, Clearwater City Hall Annex, 10 Missouri Avenue South, Clearwater, Florida, Honorable Thomas J. Downey, (chairman of the subcommittee) presiding.

Members present: Representatives Downey, Bilirakis and Young.

Staff present: Subcommittee on Human Services: John Olinger, Majority Staff Director; Moya Benoit, Majority Research Assistant; Natalie Cannon, Minority Staff Director.

Representative Bilarakis staff: Patricia DeLoatche, Legislative Assistant; David White, Press Assistant; Patricia Faber, District Administrator; Sonja Stefanadis, Case Work Director; Patti Sinklewicz, Scheduler; and Tom Irvin, Special Projects.

OPENING STATEMENT OF CHAIRMAN THOMAS J. DOWNEY

Mr. DOWNEY. As Chairman of the Subcommittee on Human Services of the House Select Committee on Aging, I am pleased to be here this morning, and would like to thank my colleague, Mike Bilirakis for providing us with the opportunity to hold this hearing today and the city of Clearwater for their hospitality and warm welcome.

As you know, and all of you should, Mike has been an active advocate for the rights of senior citizens since he came to Congress in 1982, and I applaud his efforts to improve the quality of life for the seniors of the 9th District of Florida. I would also like to recognize and thank my friend, Bill Young, for joining us this morning. Bill actually got to the Congress before I did, and I have to defer to him. He is senior to me. Bill's presence emphasizes his continued commitment to the needs and concerns of his constituents. I am delighted he could be with us today.

Our hearing focuses on the needs of the frail elderly and what might be done to improve the quality of services available to this particular segment of our aging population. The frail elderly are, as all of you know, a diverse population group which cannot be defined in simple terms of age, geography, economic status or race. What binds them together are their physical conditions and limitations. The Subcommittee on Human Services has oversight responsibility over the Older Americans Act, which is the primary provider of social and human services for millions of elderly Americans

across the Nation. This year we are proud to be celebrating the silver anniversary of the Older Americans Act.

The Older Americans Act is scheduled for reauthorization in 1991. It is consistent with our role as an oversight subcommittee to convene hearings such as this in order to bring ideas together and hear views on how the different provisions of the hearing will be implemented.

As you may know, our first hearing on this subject was held on February 7th in Washington, DC. At that hearing Doctor Joyce Berry. Commissioner-Designate of the Administration on Aging laid out the Administration on Aging's plans and goals for 1990 and beyond. We plan to hold a hearing in late March which will include representatives of the aging leadership and community to hear their thoughts on how the act is being implemented and what recommendations they might make, if needed.

These hearings provide us with a framework for what our committee and what Congress should consider when reauthorizing the Older Americans Act next year.

The issue of long-term care has gained widespread attention in recent months and years. The need for a national policy on long-term care led to the creation of the U.S. Bipartisan Commission on Comprehensive Care, better known as the Pepper Commission, and we look forward to a lively, and I hope, fruitful debate on their recommendations which were made just last week to the Congress. While we are debating those recommendations there is a lot that needs to be done in the meantime.

The Older Americans Act is our first line of defense in solving the problem of long-term care because its services enable the elderly to remain independent and active within their communities, thereby providing an alternative to institutionalization.

We have with us today a variety of witnesses who represent many different aspects of our aging community and who can assist to define the question and find the answers to problems the elderly are facing, and I look forward to hearing their testimony today.

Let me just say, I know many of you will want to speak or hear something that you do not like and say so. This is, unlike probably the town meetings that Mike and Bill have, a hearing, not a public hearing, but a hearing where we listen to witnesses. If there is something that you would like to say to us, we are happy to listen after the hearing, and if there is something more that you would like to give to us, a statement of some sort, we would be happy to take it and include it in the record.

At this point we are happy to hear from two citizens who will comment about their concerns, Mrs. Elizabeth Palmer and Mr. Vincent Cavo.

Oh, I am sorry. Before we begin that, Mr. Bilirakis and Congressman Young probably have opening statements. Forgive me. Mike?

Mr. BILIRAKIS. I will yield to my senior colleague—not senior in age, but senior in time in Congress—Bill Young, before I give my opening statement. Bill.

STATEMENT OF REPRESENTATIVE C. W. BILL YOUNG

Mr. YOUNG. Well, Mike, first let me congratulate you for your initiative in bringing this subcommittee hearing to Pinellas County and the work that you do in the Congress on the issue. And thanks to our colleague and friend, Congressman Tom Downey, for being willing to do that. Although being in Pinellas County in March is not all that bad, Tom.

We live with the issue of the frail elderly and the issues dealing with the Older Americans Act on a daily basis, and we are very proud for this opportunity for our constituents to present to you some of the problems they see. And just let me close by saying that here in Pinellas County we have a good representation of what the rest of the country is going to be like in, say, 20 years. We have a very high average age. We have a higher concentration, as you pointed out, Mr. Chairman, of Americans 85 years of age and older than any place else in the country, and that brings about with it particular problems. The rest of the country is going to recognize this as the life span grows longer. Life expectancy is greater and more power to that. So we think that an awful lot can be learned here by our colleagues in the Congress, and we are very pleased and proud that you are here to be part of it.

I have a complete statement I would like to submit for the record.

Mr. DOWNEY. Absolutely. Without objection, it will be made part of the hearing record.

[The prepared statement of Mr. Young follows:]

OPENING REMARKS OF CONGRESSMAN BILL YOUNG

HEARING OF THE HOUSE SELECT COMMITTEE ON AGING

SUBCOMMITTEE ON HUMAN SERVICES

Clearwater, Florida -- March 5, 1990

Mr. Chairman, I want to thank you for convening this special hearing of the Select Committee on Aging to discuss ways in which we can improve the services we provide for our nation's senior citizens, especially for those who are 85 and older.

My colleague from Florida, Mike Bilirakis, is to be commended for his efforts in this regard and for his work to arrange for this field hearing. As a former member of the Aging Committee, he has established an outstanding reputation for his work in the Congress to assist older Americans.

Mr. Chairman, through the Older Americans Act, the federal government provides a wide array of services to assist older Americans, especially those living on very limited fixed incomes. Of special concern at this hearing, is the availability of services to the so-called "frail elderly", those over 85 who may be living alone or have special needs. We are particularly sensitive to their needs here in Pinellas County where we have one of the highest concentrations of senior citizens anywhere in our nation and according to the Census Bureau, the highest concentration of Americans over 85.

During this hearing, we will hear first hand of the vital support the Older Americans Act provides to local senior citizens and Mr. Chairman, you will see why we are so proud of the many local agencies which have developed outstanding programs to meet their needs. The comprehensive list of programs and services administered by Neighborly Senior Services and the Tampa Bay Regional Planning Council, as well as by the the local state, county, and municipal human services departments are recognized nationally for their quality and effectiveness. You will also meet during this hearing several of our local leaders who have devoted their time and attention to caring for our older population.

Mr. Chairman, in addition to emphasizing the importance of the Older Americans Act programs, this hearing was also requested to look into a special hardship that has been placed upon our state by a court ruling two years ago that forced the state to recalculate the way it distributes Older Americans Act funds to the area agencies on aging. As you know, the new formula no longer takes into account the high proportion of our county's residents who are 85 and older. This reallocation of funds has caused a funding shortfall for a number of local programs including meals on wheels, transportation services, and community care. Not only does this

impact on their ability to provide current services, but it will make it more difficult to meet the increasing demand for these programs in the future.

Through the hard work of our Pinellas County state legislative delegation, we have been able to temporarily offset the impact of this court ruling with a special appropriation of state funds. However, it is critical that we find a permanent solution at the federal level to correct this problem.

Legislation I have cosponsored that was introduced by my colleague Mr. Bilirakis would require that Older Americans Act funds be distributed using a formula that takes into consideration the population of seniors in this age bracket. As a member of the House Appropriations Subcommittee which funds the Older Americans Act programs, I have expressed to federal officials my concern about the impact the court decision has had on our county and you can be sure I look forward to following up this hearing to work with you and Mr. Bilirakis to provide a legislative solution, especially as we prepare for the reauthorization of the Older Americans Act.

Once again Mr. Chairman, thank you for convening this special hearing.

STATEMENT OF REPRESENTATIVE MICHAEL BILIRAKIS

Mr. BILIRAKIS. Thank you, Mr. Chairman. As a former member of your Human Services Subcommittee, back when Mario was the chairman, I certainly would like to join Bill and all the people of the 9th Congressional District in welcoming you to this area, and I might add that your loss of an awful lot of nice, good people, is my gain, and I am sure Bill would say the same thing. We also thank you for holding this hearing here and appreciate Bill Young taking time away from his busy schedule to attend.

This is grassroots in action. I feel and have always envisioned Congress being in action—not sitting in an ivory tower up there basically thinking we know everything about everything and shoving it down the people's throats, as we tend to do every once in a while, but actually coming down and talking to people and listening to them and finding out what the problems really are.

Mr. Chairman, the issue before us today, as you said, is one of great importance to the State of Florida. As a Federal legislator and long time supporter of older American programs, I was gravely disturbed by last year's court decision that ordered the State Department of Health and Rehabilitative Services to pull $1½ million from Pinellas and Pasco counties' Older American programs. Many of you in this audience know of the outcome of the lawsuit which claimed that Florida's formula for allocating Older Americans Act money was unfair.

The court decided that South Florida, with its higher concentration of low income minority elderly, was entitled to a higher percentage of available funds than the Tampa Bay area.

While I strongly endorse—and I emphasize that—strongly endorse Federal funding for low income minority older person, there is no doubt in my mind that the frail elderly have needs as great and as pressing. The Tampa Bay area, in particular, has one of the highest percentages of persons 85 and older in the State of Florida as well as in our Nation, and I have always sought to encourage Congress to pass legislation ensuring that services will be provided to our frail elderly population, as well as to other disadvantaged older persons.

And for this reason I introduced H.R. 1879, a bill designed to establish a new category—new category—not replacing a current category, but establishing a new category of disadvantaged elderly for those age 85 and over. And once again, it is not my intention to reduce funding levels received by other categories already designated by the Older Americans Act. I simply want the frail elderly to be taken into consideration by States when Older American funds are distributed and, in view of the court's decision, the only remaining way, it seems to me, to accomplish this goal is through Federal legislation.

So the purpose of this hearing, as has been so ably said, is to present to the subcommittee the true grassroots needs of the frail elderly, what types of services are currently available for them and the costs to the Federal, State, and local governments to fund these programs. And I, too, look forward to hearing from our witnesses because they are the experts in this field, and I believe they will provide the subcommittee with valuable insights, especially since

most deal with the frail elderly on a daily basis. Thank you again, Mr. Chairman.

Mr. DOWNEY. Thank you. Mrs. Palmer, Mr. Cavo, thank you very much for coming. Mrs. Palmer, we are going to hear from you first, ma'am, and if you would speak into the microphone and do so at your own pace. You are among friends. None of us here are going to hurry you. Same thing is true for you, Mr. Cavo. When it is your chance to speak, just assume you are among friends. Ma'am, if you would begin.

PANEL ONE, CONSISTING OF ELIZABETH PALMER AND VINCENT CAVO

STATEMENT OF ELIZABETH PALMER

Mrs. PALMER. I must say, this is a very unexpected spot I find myself in right now. I did not realize until I saw my name on the program that I was supposed to do anything except just come and be a participant, but if there is anything I can do to help our age group, I shall certainly be happy to try.

Let me say I am 88. I do not hear very well, and I do not see very well, but I am happy to do anything I can. I was on the CCE program. My husband was first put on it. He died a little over a year ago at age 95, and because of the CCE program, I was able to keep him at home, happy and comfortable until the end, which is what he wanted to do, and is what I would like to do too, if I can. He was frail but not ill. I was first having a CCE worker who came in to stay with him so I could ride the Sunlift Shopper into town to do my shopping once a week after I no longer could see to drive. I did not like to leave him alone so I felt very comfortable leaving him in the hands of a home aide, who would get him up and give him his brunch and stay with him and keep him happy until I got back. After he died, a little over a year ago, they retained me on the program, which is really necessary and very, very helpful to me to stay in my own house. The aide comes in once a week. She does light housekeeping for me. She checks over my clothes to see if I am not covered with spots that I cannot see. She can read some things for me, and it is just a great help to be able to save up small problems to discuss with her when she comes.

I also, because of this program, have a panic button in my house, and it was due to that that I was able to get help when I hurt my back at one time trying to lift my husband. So that was—and it is a comfort to know that is in the house with me in case I need it.

I recently talked with a friend of mine who is in my age group who has an ill husband, and she heard about the CCE Program, and she said—and they have been greatly written up in the throw away papers. There has been article after article about what they do, but when she went to them for help, she found that there was a long waiting period, and this has really distressed her.

What else can I tell you? I am happy to be on this program. I think it is a wonderful thing. As I get more frail, I may need more help. Right now I am doing fine, but it has been a wonderful help to me.

[The prepared statement of Ms. Palmer follows:]

March 5, 1990

Testimony to House Select Committee on Aging
Sub Committee on Human Services

Congressman Tom Douney, Chairman

Congressman Mike Bilirakis

Several years ago one of the nurses sent in by the doctor to help me care for my over 90 year old husband suggested he should be on the CCE program.

My husband was not ill but aging, and he wore a urostomy pouch for which he needed help. I was in my 80's, and my eyesight was failing to the extent that I could no longer accurately center this appliance over the stoma, and we were running into constant problems. After two cataract operations it was decided I had Macular Deterioration. I sold my car and transportation became a problem, too.

CCE has been a wonderful program for me. They set up a program whereby an aide would come in once a week to help my husband get up, bathe him and give him his brunch, she also did light housekeeping. During this time Sunlift transportation would come by to take me grocery shopping and my husband was not left alone. Due to this arrangement I was able to keep my husband at home, happy and comfortable, until he died last year at age 95.

As I was 87 at that time, with very poor eyesight, and because I had hurt my back trying to lift my husband I was admitted to the program. I now have an aide who comes once a week. She changes my bed, does light housekeeping and laundry, checks my clothes for possible spots etc., that I can no longer see. She also checks me to make sure I am doing alright. A Registered Nurse comes by periodically to take my blood pressure too. I still use Sunlift service once a week.

CCE also provides an emergency alert system, and with just one touch of a button help can be summoned. This system proved very helpful the day I hurt my back, and it is a comfort, especially at night when there is no one here.

The aide who comes to me, by her presence and listening has helped me clarify some problems that I was struggling with, being alone after 63 years of marriage.

I could not stay here, in my own home, without this service.

Sincerely, Elizabeth M Palmer

Elizabeth Palmer

Mr. DOWNEY. Thank you very much, Mrs. Palmer. Mr. Cavo?

STATEMENT OF VINCENT CAVO

Mr. CAVO. Congressmen Michael Bilirakis, Tom Downey and Bill Young, ladies and gentlemen, I made a few notes here because my head will not keep everything in there.

I am pleased to have the opportunity to share several of my thoughts with you all. My name is Vincent Cavo. I am the caregiver to my wife, Regina. She and I live in the city of Clearwater.

I am 80 years of age, and my wife of 47 years is 92. She has some sort of dementia. Whether or not she has Alzheimer's, neither I nor the doctors seem to know. The problems with her memory started about 6 years ago and she has been regressing ever since. Every day I seem to have to do more and more for her. Sometimes it becomes very difficult to see her becoming less able to take care of herself, or do anything for herself.

Regina has been going to the Neighborly Senior Citizens Center for about 4 years. This program has helped both her and me. And believe me, it has helped me. The day care program gives me the opportunity to keep our family affairs in proper order, to see that our home is taken care of, and have a couple of hours each week for myself.

Our retirement income does not allow us to meet the Medicaid requirements. I am not sure how much longer I can continue to be the caregiver that Regina requires. I worry about what will happen to Regina if my health fails. I worry about what will happen if her health gets to the point of needing long-term care in a special institution. Where can I get the assistance I may need without becoming impoverished?

The day care center is so vital to me and so vital to Regina. In Pinellas County there are over 295,000 persons over 60 years of age. One hundred thousand of these people are over 75 years of age, and 24,000 are 85 years of age or older. Without the Older Americans Act programs many of our elderly's problems would become more severe, just as mine would.

I just do not know where or how I would be health-wise today if I had not had the Neighborly Senior Services Adult Day Care Program to assist me with Regina's care. The staff at Clearwater Adult Day Care Center is willing to help and are good to Regina.

The Adult Care Program needs financial assistance now in order to carry on their good work. The Older Americans Act is very important to the well-being of our older citizens. Please give special attention to our older elderly who are now living past 85 years of age. The Adult Day Care Program is so important to so many every day.

I could go on and on and on, but I imagine you gentlemen know what I am driving at. So I will conclude with thanking you for your time. Thank you very much.

Mr. DOWNEY. Thank you, Mr. Cavo, and thank you, Mrs. Palmer. I think you have made it very clear to us that in your case the community care program makes a very big difference to your life, and one would hate to think of the alternatives—what you would be faced with without that. And for you, Mr. Cavo, with the adult

day care. Both are important programs and personally programs I strongly support, and I know Mike and Bill do as well.

Mike, do you have questions for the witnesses?

Mr. BILIRAKIS. Mr. Cavo, I am sure all of us here certainly can easily place ourselves in your shoes, if that sort of thing is even possible. As to your concern regarding what happens to Regina if something were to happen to you—I mean, you are telling us basically that as long as you are around and with community care and Neighborly Senior Services and whatnot, she is being taken care of, but what if something were to happen to you?-How do you feel she would be taken care of? You have to talk into the mike, sir, because I know it is very—

Mr. CAVO. A few months ago I had some papers drawn up by an attorney so that the bank would take over and see that Regina was taken care of as long as my money held out, and if and when it ran out then they would have to see that she was—continual care with government assistance or State assistance.

Mr. BILIRAKIS. She is at home now?

Mr. CAVO. Right now she is at the Clearwater Adult Day Care Center.

Mr. BILIRAKIS. But I mean she is ordinarily at home and then she is at Clearwater Community—

Mr. CAVO. I take her there 4 days a week. I keep her home in the middle of the week to give her more rest, and I take her there Monday, Tuesday, Thursday and Friday.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chairman.

Mr. DOWNEY. Bill?

Mr. YOUNG. Mrs. Palmer, Mr. Cavo, thank you very much for sharing your personal experiences with us.

I believe that I got from your statements that you actually prefer to care for Regina, for example, at home rather than having her in an institution where you would have to visit? As long as you are able, you would prefer to have her at home?

Mr. CAVO. That is correct, 100 percent correct. I would rather have her at home as long as I am able to do it.

Mr. YOUNG. I think that is an important point because, you know, one of the strong proposals that Congressman Pepper had offered and promoted in Congress was more emphasis on home health care so that more people could stay together in their homes during these difficult times, and I thank you very much for what I think confirms the belief of many of us that home health care and long-term care is extremely important.

Mr. CAVO. Correct.

Mr. DOWNEY. Thank you both for your excellent testimony.

The committee will next hear from a panel comprised of the Honorable Curt Kiser, who is chairman of the Claude Pepper Commission on Aging here in the State of Florida; Margaret Lynn Duggar, who is the Vice-Chairman of the Claude Pepper Commission on Aging, and Larry Polivka, who is the Assistant Secretary for Aging and Adult Services and Doctor William Hale, who is the Medical Director of the Florida Geriatric Research Program.

Senator Kiser, if you would begin.

PANEL TWO, CONSISTING OF THE HONORABLE CURT KISER, DISTRICT 19, FLORIDA SENATE, AND CHAIRMAN, FLORIDA CLAUDE PEPPER COMMISSION ON AGING; MARGARET LYNN DUGGAR, VICE CHAIRMAN, FLORIDA CLAUDE PEPPER COMMISSION ON AGING; LARRY POLIVKA, PH.D., ASSISTANT SECRETARY FOR AGING AND ADULT SERVICES, HEALTH AND REHABILATATIVE SERVICES; AND WILLIAM E. HALE, M.D., MEDICAL DIRECTOR, FLORIDA GERIATRIC RESEARCH PROGRAM, DUNEDIN, FLORIDA

STATEMENT OF THE HONORABLE CURT KISER

Mr. KISER. Thank you. Mr. Chairman, Congressman Young and Congressman Bilirakis, thank you for giving me the opportunity to speak to you today on the subject of meeting the needs of the frail elderly. I am the State Senator representing this area, therefore representing 24,000 people over the age of 85 years plus in Pinellas County. I recently accepted the position of chairman of the Florida Pepper Commission on Aging, which is charged to present a master plan on aging policy, and which as a group has selected the 85 year old plus population as a high priority issue.

Congressman Claude Pepper lived to be 89 years old, and we know that he was perfectly capable of caring for himself, as are many other 85 year old and older persons. He lived a life advocating for the many older and frail Americans who needed his help. We, in the State Senate and in the Pepper Commission, are convinced that the frail elderly need our help and our immediate attention. They need help in a concerted, coordinated, passionate, persistent, and highly planned and targeted approach.

I am concerned because we currently have over 201,000 persons in our State who are 85 years old plus. In just 4 years the number will grow to over 257,000 people, and by the year 2000 Florida will embrace a staggering 372,000 85-year old plus persons.

My colleagues in the legislature and on the Pepper Commission are worried because we know that too many of this group have significant and severe problems. Poverty is an issue. National data reflects that close to 19 percent of the group are poor, and we have all learned persistent poverty can lead to abandonment of hope. So many live alone and cannot rely on children to fully care and provide for them because, frankly, their children are older too. So many have limitation in activities, half have disabilities and 23 percent have severe limitations in activities of daily living. Forty-seven percent of our 85 year old plus have Alzheimer's or dementia. That is close to 95,000 people.

Our Florida nursing homes are replete with the 85 year old group. Forty-four percent are over 85 years old. In Florida we believe in support for good nursing home care. We know that many older people do not want to go to nursing homes. Additionally, the cost is highly troublesome from a State and Federal budgeting standpoint.

We are recommending to you a series of proposals to address the frail elderly and to keep them in their homes as long as possible.

Number one, within the Older Americans Act create a focus on the 85-year old plus group in the nutritional and social services programs. Target resources through the services program—I am

sorry—target resources through the area agency plans, needs assessments and State and local allocation methods.

Number two, ensure that the Older Americans Act providers offer a full range of services to the frail older persons. I worry that our care to frail older people can be so limited that we almost participate in neglect of older people when we do not give enough care in the home to keep them comfortable.

Three, area agencies are required to have advisory councils. Perhaps we should require each council to have an 85-year old person or the caregiver of an 85-year old on these councils to help us all understand the enormous stresses of the frail elderly.

Fund the Title III-D, frail elderly component in the law to a level that will reshape the Older Americans Act to meet the needs of the 1990s and beyond.

As the Select Committee on Aging, we suggest that you look to the Older Americans Act as a solution and that the Federal Government and the States also seek coordinated solutions with other programs such as: a, increased Medicaid waivers targeted to the 85 year old plus and make it flexible to adopt to this new emerging population; b, our State is providing many Alzheimer's services such as respite and support groups. We need Federal assistance as well as a coordinated and intense approach to the epidemiological research and demonstrations on service delivery models and support caregivers; c, expert planning, research and forecasting pertaining to the 85 year plus in order to be better prepared in laying out a comprehensive plan for this population; d, information and education of the public so they too can understand the special needs of our future aging society where the frail elderly are the fastest growing age group.

We have an important mission. The Claude Pepper Commission on Aging in Florida is striving to create a plan for Florida, which will address all matters relating to our aging policy. Now it is time to unite with the U.S. Congress in a corresponding effort to give the frail elderly a positive and healthy future. All levels of government must work together to strengthen the Older Americans Act to guarantee independence and a stable future to the frail elderly of Florida and of this Nation. Thank you.

The prepared statement of Senator Kiser follows:]

WRITTEN TESTIMONY

BY

SENATOR CURT KISER

DISTRICT 19, FLORIDA SENATE

1968 BAYSHORE BOULEVARD

DUNEDIN, FLORIDA

TO THE DISTINGUISHED

SELECT COMMITTEE ON AGING

SUBCOMMITTEE ON HUMAN SERVICES

U.S. HOUSE OF REPRESENTATIVES

MARCH 5, 1990

Mr. Chairman and members of the committee, I thank you for the opportunity to present written comments on behalf of Pinellas County and of the state of Florida, in my capacity as State Senator, and as Chairman of the newly established Florida Claude Denson Pepper Commission on Aging.

The Pepper Commission was named in honor of a great Floridian and American - a great man who remained independent as well as physically and mentally sound throughout his lifetime. Congressman Claude Pepper, who lived to be 89 years old, used his wealth of knowledge and experience as an advocate for a positive and healthy future for America's elderly.

The Commission is charged in Chap. 410.505, Florida Statutes, to create a master plan for Florida which will address all matters relating to our aging policy. Because of the State's rapidly growing 85+ population (the frail elderly) and its many unique

needs, we have targeted that specific group as one of our top priorities.

The Florida Pepper Commission on Aging is convinced that the frail elderly need our help as well as the help of Congress and the federal government. There is increasing demand for immediate and focused attention on this population group. Our approach to the issues must be based on sound and expert planning, providing insight into the present problems while developing step by step solutions to ensure the health and welfare of our elderly citizens thus preserving their dignity and giving them the best services and care we can offer.

We currently have over 201,700 persons in our state who are 85+. In four years the number will swell to 257,000, and by the year 2000 Florida will embrace a staggering 372,000 85+ persons.

Florida policy makers are concerned for the following reasons:

* GROWTH IN NUMBERS

The following table best demonstrates our dramatic growth:

FLORIDA'S 85+ COMPARED TO UNITED STATES IN THOUSANDS

UNITED STATES

	1980	2000	2020	Percentage Growth 1980-2020
under 65	201,990	233,034	242,200	+20%
65+	25,714	34,921	51,900	+(102%)
85+	2,271	4,926	7,600	+(235%)

FLORIDA

	1980	2000	2020	Percentage Growth 1980-2020
under 65	8,059	11,602	13,495	(+65%)
65+	1,688	3,069	4,827	(+186%)
85+	117	372	560	(+370%)

(Source: Rothman, "Meeting the Challenge, Organizational and Policy Implications for Long Term Care in Florida", Executive Summary 1987.)

While we are stunned by these figures for Florida, it is apparent that the nation will also face enormous growth in the frail elderly. According to the recent study by the Urban Institute, "Needs of the Elderly in the 21st Century", "there will

be between 8.7 and 12 million frail elderly in 2030 (depending on the mortality rate projected), compared with 2.5 million in 1984.

In Florida the 85+ group is becoming a bigger share of our over 65 group. In 1985, they comprised 7.9% of our total 65+ group. In 1990 they comprise 9.1%. By the year 2000, we expect they will comprise 12%. (Data from 1989 Florida State Health Plan and Institute on Planning.) The 85+ is the group likely to experience the greatest percentage increase in the next decade.

By the year 2000, this segment of the total population is expected to grow by 210%.

* POVERTY

The frail elderly are often poor. In the "Other Side of Easy Street", Villers Foundation 1987, we noted the data and the poignant statement:

Exceptionally High Poverty rates among 85+ in the U.S.

85+	18.70%
85+ Women	19.7%

"Persistent poverty can lead to the abandonment of hope."

Using these rates and straight line projections, we anticipate that in ten years not only will Florida have 372,000 people over 85, but close to 70,000 will be poor.

In fact, the Urban Institute found that individuals below the poverty level were six times more likely to be institutionalized

than individuals above the poverty level. (Cited in the 1989 Florida State Health Plan, Vol. III, July 1989.)

* DISABILITIES AND RISK OF NURSING HOME STAY

The human problems of poverty and limitations in activities of daily living are of great concern to Florida. We know that "the prevalence of ADL (activities of daily living) limitations increase with age. For example, only 11% of the persons between ages 65 and 74 in 1984 had one or more ADL limitations while about half of the persons 85 and over in 1984 were similarly disabled. In 85+ groups, over 23% have four or more ADL limitations.
(Source: Based on combined sample of persons from 1) the 1984 National Health Interview Survey Supplement on Aging, and 2) the 1985 National Nursing Survey, as reported in needs of Elderly in 21st century.)

Part of our dilemma is the large and growing number of individuals with Alzheimer's disease. Using recent data from the Florida State Health Plan and the Florida Committee on Aging's report on Better Living for Seniors, it is estimated that approximately 20-25% of 85+ are suffering from this dreaded disease.

In Florida almost 50,000 persons experienced a nursing home stay last year. The Florida Hospital Cost Containment Board reports that 43.8% of the residents were over 85.

PROPOSALS

Our proposal for these enormous problems are to keep people in their homes as long as possible. This is where most older people want to be. Additional proposals include:

* A consistent and coordinated federal and state initiative.
* Strengthening the Older Americans Act to focus on the 85+ through the area agency plans, needs assessments and state and local allocation formulas for nutritional and social services.
* Ensure that the Older Americans Act providers of care offer complete care programs to this group. Otherwise, a minimal care plan for a frail 85+ person could mean neglect of the complex needs of the client. In the end, a minimal care plan could be more harmful than helpful. Special monitoring of these care plans may be necessary.
* Consider requiring the Older Americans Act advisory councils to include in their membership an 85+ person or a service provider of an 85+ individual to help us better understand their daily stresses and suggestions for program solutions.

* **Fund the Title III-D portion of the law, which is dedicated to the Frail Elderly to adapt the Older Americans Act to the emerging older old population. Funding the frail elderly component will reflect a 1990 vision for independent living and convenient community-based care.**

The solutions for the frail elderly must be addressed as coordinated approaches with other federal and state programs such as:

* Increased Medicaid waiver programs targeted to the 85+. These waivers would promote flexibility in programming allowing states to adjust to the special needs of this population. The waivers represent a true federal-state cooperative funding effort. We hope to see advanced work in designing, both home-based waivers and waivers for supported residential living arrangements.
* Increased cooperation in targeting Alzheimer's victims and caregivers. Florida has a major Alzheimer's disease Initiative and we are proud of its progress in offering respite care, day care, support groups, and research. We recommend increased federal support in areas of epidemiological research and demonstrations

in the designing of social services, model living environments, and special assistance to caregivers. Research and demonstrations could be developed with the assistance of the Administration on Aging and the National Institute on Aging.

* Concentrated research, projections and detailed planning pertaining to this group. It appears that the nation and Florida must have a comprehensive plan to manage its resources offering prevention, as well as home based, residential institutional care to this group. Preparing a plan may be our greatest challenge calling for knowledge, leadership and compassion.

* Information, and education of the public so they too, can understand the special needs of our future aging society where the frail elderly are the fastest growing age group.

It is fitting and proper that the Commission's report is originating from Pinellas County - this is the area which shall be impacted the most by what our state and federal government choose to legislate.

It is most appropriate that Pinellas County, an area housing one of the highest number of elderly residents, and known

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throughout the world as a retirement haven, be considered for any pilot projects and programs suited for the elderly.

Sources of Information:

A. Staff preparation of paper:

June L. Noel, Executive Director

Florida Pepper Commission on Aging - (904)488-8922

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Mr. DOWNEY. Thank you, Senator Kiser.
Ms. Duggar.

STATEMENT OF MARGARET LYNN DUGGAR

Mr. DUGGAR. Chairman Downey, Congressman Young, Congressman Bilirakis, distinguished guests, the Older Americans Act contains references to 36 elements that are used by States to determine their intrastate funding formula under the act. In addition the act contains language such as "adequate", or "with particular attention to", which leave unclear whether a particular element is a requirement in a funding formula or not. However, among those 36 elements there is no special reference to the 85-and-older population, the fastest growing age segment in our State and in our Nation.

Persons age 85 and older are more likely to be frail, more likely to have chronic and debilitating diseases, more likely to be poor, at least two and a half more times as likely to suffer from Alzheimer's disease, and at greater risk of institutionalization. For these reasons, H.R. 1879 needs to be incorporated into the Older Americans Act.

One of the unfortunate results of the lawsuit that Congressman Bilirakis referenced was brought against the State of Florida, referenced to our intrastate funding formula, was the declaration by the Federal judge that Florida could not continue to use the factor of age 75 and older in its intrastate funding formula. As a result, we believe, it would be essential for the 1991 reauthorization of the Older Americans Act to include specific language to enable States such as Florida to target funds to this important segment of our older population.

One additional point I wish to make relates to low income persons. The act places considerable waiting on the needs of low income older persons. In fact, possibly too much waiting, from my experience. I suggest that consideration be given to an income standard that addresses moderate income persons as the target because persons of moderate income are eligible, for instance, for Medicaid assistance in nursing homes, provided their assets met the criteria. It seems short-sighted not to target these persons with preventive and Inhome services to delay or avoid that institutionalization instead of focusing primarily on just the low income or poverty level individuals in the act.

I believe the 1991 reauthorization offers many opportunities for Congress to fine tune an excellent piece of legislation, and my written testimony includes additional comments as well.

[The prepared statement of Ms. Duggar follows:]

WRITTEN TESTIMONY

OF

MARGARET LYNN DUGGAR

TO THE

SELECT COMMITTEE ON AGING

SUBCOMMITTEE ON HUMAN SERVICES

U.S. HOUSE OF REPRESENTATIVES

MARCH 5, 1990

Mr. Chairman and Members of the Committee, thank you for the opportunity to present testimony on the needs of frail older persons and how those needs can be met through the Older Americans Act. In my capacity as Vice-Chair of the Claude Pepper Commission on Aging, I am frequently reminded that:

- The 85 and older population is Florida's fastest growing age segment, with over 200,000 persons in 1990 and approaching one third of a million persons by the turn of the century.
- This 85 and older population is extremely vulnerable to health problems that are linked to longevity; to the complications that arise from multiple physiological problems; to the decreasing values of pension plans, Social Security and other retirement incomes; and to diminished socialization due to reduced mobility and inadequate community resources such as transportation.

The challenge to our nation will be to find community-based services and options that respond to the most compelling desire of persons: how to remain independent. The Older Americans Act has begun to address these needs through Home-Delivered Meals, In-Home Services and through the newly-created Part D of the Act.

Florida's Community Care for the Elderly law has In-Home Services similar to those of the Older Americans Act. Most often, these services are provided by the same providers. In 1987, an independent evaluation of the Auditor General substantiated that, applying the most conservative methodology, the Community Care for the Elderly program was not only cost-effective but in fact, more than paid for itself in nursing home savings. Under the state's program, we were able to serve nursing home eligible persons in their homes for 20-25% of the medicaid cost of nursing home care. While not all nursing home residents can be maintained in community settings outside skilled nursing facilities, many frail older persons can be kept independent in their homes with supportive services such as those offered through the Older Americans Act.

The Older Americans Act, through the 1991 reauthorization, needs to target services to this 85 and older population in the intrastate funding allocation and in the targeting and funding of services to homebound persons.

Over the past decade, there has been dialogue over targeting the Older Americans Act programs exclusively to the poor. The needs of the low-income elderly are important. However, it would be unwise to limit services under the Older Americans Act only to low-income persons. As previous research from the U.S. House Select Committee on Aging reflected, nearly two-thirds of the private pay nursing home patients spend down to become medicaid eligible within thirteen weeks. To deny these individuals the opportunity to receive in-home services because of incomes and assets just above the poverty line would be unfair to them and costly to public funding sources.

The reauthorization of the Older Americans Act needs to provide additional emphasis on targeting the 85 and older population, on access of older persons to services, on improved coordination at the community level, on caregiver support, on Alzheimer's Disease victims and their caregivers, on creative technology to enhance in-home services and to assist frail persons and their caregivers, and on creative housing design that enhances independence.

Thank you for the opportunity to present this testimony to you today.

Mr. DOWNEY. Thank you, Ms. Duggar. Doctor Polivka?

STATEMENT OF LARRY POLIVKA, PH.D.

DR. POLIVKA. Thank you, Congressmen, and welcome to Florida. As Senator Kiser has already mentioned, Florida has one of the largest and fastest growing older populations in the country. We now have—20 percent of the population is over 65 and we will experience somewhere between an 80 and 100 percent growth in the over-85 population in the 1990s. So truly the 1990s will be the age of aging in Florida. In that sense, the State is also truly a laboratory for policy in this area, or for how we are going to deal with a society that is increasingly growing older.

In the last reauthorization of the Older Americans Act, Section III-D was included which places emphasis on the frail elderly. The major problem with that, however—and I am sure you have heard this to the point that you must think we are all repeating the same tune—but it is inadequate funding. Five million dollars was included to address that title, and if you apply that across the States, in Florida it would amount to something less than $2 per person over 85. So you really have to wonder about how much of a—if we will ever reach the point of critical mass in terms of effectively dealing with the problems of people over 85 without increased funding, particularly in that area.

There is also a problem with the Older Americans Act as it relates to services. For the most part the act is very flexible. It provides for a range of programs right across the spectrum of need of older people, but it does not include case management, and in my experience—and I am sure in the experience of many people in this room and at this table—without case management you are missing one of the crucial pieces in terms of developing a complete continuum of community care for people. It is an absolutely essential service that should be added to the bill as you go through the reauthorization process.

But I think most fundamentally the important issue is funding. We have—in Florida, for instance, we have had to move over the last couple of years money from the congregate meals part of the act to home delivered meals and that is because of the increasing number of frail elderly in the State and the increasing number of people over 85 that can not visit congregate meal sites and have to be served in their own homes if they are going to be served at all.

It is also the case that even with an increase in the number of home delivered meals, we have not been able to meet the need there because we are serving something less than one meal a day, 5 days a week, when we really need the capacity to serve two or three meals a day, 7 days a week. One more instance or example of the inadequate funding for this piece of legislation.

We have two programs that have been described wonderfully by the two people this morning, the Community Care for Elderly and Home Care for Elderly programs that are State funded, general revenue programs in the State, but even with increases, steady increases in those programs, we have not been able to achieve more than one-third of the need met for community care for the elderly in this State, and one reason for that in my judgment is because of

the declining real dollars going to the Older Americans Act over the last 5 years. Even as the population has increased by one-third over 65 in this State, the real value of that program in terms of real dollars against inflation has gone down. It does not seem to me as if that is the direction that we really should be—that we really should have in this program, the Older Americans Act. It should be quite the reverse, in fact.

To the extent that we do not fund these community programs, the Older Americans Act, the Community Care for Elderly Program and Home Care, we will be spending money in increased institutional care. That is a fact. So it is either a matter of providing more funding for people in programs where they would prefer to be or we are going to provide, at a greater cost, programs that they would prefer to avoid and that we know how to avoid with the experience we have had with Older Americans Act and these other community programs.

Finally let me say that in Florida our majority priorities are tied into these issues. One, we are interested in preventive health care, which I think Doctor Hale will talk about this morning, both in terms of physical and mental health care. And we are also very much committed through the leadership of people like Senator Kiser and Margaret Lynn Duggar and the Pepper Commission in developing a complete continuum of care that can offer people alternatives to institutions.

And I think that one other area besides the Older Americans Act where the Federal Government can be pivotal in this effort is in increasing the incentives for HCFA, the Health Care Finance Administration, in providing waivers to States to use Medicaid dollars to provide community services as an alternative to institutional care. In my judgment we know enough about how to provide that care now to do it cost effectively and in a way that meets the preferences of older people. We have not, in my judgment, however, seen the willingness on the part of HCFA to cooperate with the States sufficiently to take advantage of that experience and to provide those kinds of services. We need your help in that respect. Thank you.

Mr. DOWNEY. Thank you.

[The prepared statement of Dr. Polivka follows:]

HOUSE SELECT COMMITTEE ON AGING

SUBCOMMITTEE ON HUMAN SERVICES

TESTIMONY OF

LARRY POLIVKA, PH.D.

ASSISTANT SECRETARY FOR AGING AND ADULT SERVICES

STATE OF FLORIDA

Monday, March 5, 1990

Clearwater, Florida

28-537 0 - 90 - 2

State of Florida

Testimony for the Oversight Hearing of the
House Select Committee on Aging
Subcommittee on Human Services

"Meeting the Needs of the Frail Elderly"
March 5, 1990

During this year of the 25th anniversary of the Older Americans Act it is altogether appropriate that we step back and re-examine the objectives and focus of the Act. The demographics and characteristics of the aging population have changed dramatically during the last 25 years. Even more dramatic changes are expected during the next 25 years as the "baby boomers" enter their retirement years. In order to meet the needs of the new generations of elderly, the Older Americans Act will need to not only keep pace with change, but actually anticipate and lead the way toward the resolution of the new issues which will be facing an aging society.

Here in Florida we are already grappling with many of those issues since we have had the highest proportion of persons age 60 and older in the country for many years. However, the age cohort of greatest concern to us during the next 10 years and beyond are those age 85 and older. We are expecting this group to grow between 80 and 100 percent between 1990 and the year 2000. And this is the very group which experiences the greatest rate of frailty, chronic disease and impairment, both functional and mental.

Because of Florida's unique demographics we were particularly encouraged by the addition of Title III-D for the frail elderly during the 1987 reauthorization of the Older Americans Act. Less encouraging was the appropriation for this important new program: $5 million/year nationwide, which translated to about $1.75/year for each person in Florida age 85 and older! Of course, not every older person who is frail is in the 85+ age group nor is everyone who is over age 85 frail. However, this comparison illustrates just how inadequate the current Title III-D funding is to meet the needs of the frail elderly.

And just what are those needs? Besides the need of all older persons for safe affordable housing, adequate nutrition, income and access to health care, the frail elderly do have a greater need for certain specific types of support in order to "secure and maintain maximum independence and dignity in a home environment", which is already one of the purposes of the Older Americans Act Title III programs.

The first thing a frail elderly person needs from the service system is a caring and well-trained case manager who can determine exactly what the person needs through a comprehensive assessment, design the best way to obtain it for them, and then monitor their progress from time to time. This case manager should operate from a context of involving the client in all decisions and designing a service plan that encourages the maximum amount of independence and autonomy for the individual. Given the importance of case management, it seems strange that states are not allowed to fund case management services from Title III-D which was specifically created to serve the frail elderly. Perhaps this "oversight" can be rectified in the 1991 reauthorization of the Act.

Once the case manager has identified the needs of the frail individual, she or he needs a flexible and sufficient pool of resources to draw from in order to meet those needs. The Older Americans Act is already one of the most flexible funding sources which exists for older people. However, the Older Americans Act is already expected to fill a number of roles for a wide variety of target groups.

For the socially needy and rural isolated, Title III is to provide congregate meals, transportation, senior centers and group activities. For the economically needy, including low-income minorities, it's to provide a wide range of essentially free services, including meals, chore, homemaking and home repair services, and assistance in obtaining and protecting their housing and income. For victims of Alzheimers Disease, Title III-B can be used to provide specialized day care for them as well as counseling and respite care for their caregivers. And, for the frail and severely disabled, Title III-B can already be used to adapt their living environment to help compensate for their frailties and disabilities, provide therapies to aid in recovery, personal assistance, emergency alert services, and so on, while Title III C-2 can provide home-delivered meals. There is almost literally no end to the types of services that can be provided with some part of the Older Americans Act.

Once again, however, the issue is one of inadequate funding. Florida's Older Americans Act appropriations have declined in real dollars over the last eight years while the eligible 60 years of age and older population has increased by one-third. Every year we have to transfer a greater proportion of the Title III C-1 congregate meal funds into Title III-B and Title III C-2 to try to keep up with the increasing costs and growing need for supportive services and home-delivered meals for the frail elderly. In 1989, for example, 29%, or nearly $6 million, was transferred out of Title III C-1 and 62% of that amount was transferred to Title III-B for additional supportive services. (The Act does not allow any transfer to

Title III-D.) Naturally, as a consequence, we are serving fewer and fewer meals in a congregate setting and losing the health promotion and prevention programs provided at the meal sites. And, because of the inadequacy of Title III C-2 funding, even after transfers from C-1, few of even the frailest clients are receiving home-delivered meals more than once/day, five days per week. I think it's fair to say that most people would prefer to eat three meals per day, seven days per week!

We have also greatly reduced the funding for senior centers and group activities for the "well-elderly" over the past eight years in order to make more resources available to the partially dependent and dependent elderly. And this is in spite of the fact that we have two well-developed state-funded programs for the frail elderly, Community Care for the Elderly and Home Care for the Elderly. These two programs currently have a combined funding of approximately $54 million which exceeds our total Older Americans Act allocation. Despite these three substantial programs, frail elderly individuals are still being placed in more costly institutional care every day because of the lack of an adequate supply of alternative community and residential services. And this is the very group which we are expecting to double in number over the next ten years.

In summary, the needs of the frail elderly are fairly well known and can already be met within existing legislation, although the list of services fundable under Title III-D should be more flexible and should include case management. We are already targeting services to this population because, since the implementation of DRG's and the resultant early hospital discharges, we have had to shift more and more of the resources available under the Older Americans Act to the provision of critical in-home services. However, in order to meet the needs of the growing frail elderly population, funding at both the federal and state level will have to be greatly increased in the years to come.

STATEMENT OF WILLIAM E. HALE, M.D.

Dr. HALE. Congressman Downey, Congressman Young, Congressman Bilirakis, other witnesses, other distinguished guests, as a medical director of a 15-year longitudinal epidemiologic study of more than 5,000 over 65-year old persons, I am privileged to be able to participate in this hearing this morning. As you have already heard, the changing demographics and the increasing morbidity in the 85-year and older has resulted in a greater need for hospitalization, managed care and nursing home confinement, as testimony this morning as already indicated.

And the medical literature frequently contains comments stating there is not enough information available about the older American. An intelligent health policy requires that we obtain data that monitors morbidity, disability, dependency, quality of life, factors other than medical, to determine the trends as each person proceeds through these last years. Thus, biomedical and epidemiologic research becomes important for developing perspectives and solutions.

Efforts to improve the quality of old age and shorten the period of morbidity require an understanding that is not presently available from current data and information. It cannot, and should not, be assumed that there is little to be gained by conducting biomedical and epidemiologic research directed to this age group.

There is an overwhelming need to examine existing data and to continue to gather information that lets us better understand the physiologic and psychosocial processes in the 85 year old and older. One approach to this, we have found, is typified by the Florida Geriatric Research Program, a longitudinal epidemiologic study of the ambulatory elderly, being conducted here in Pinellas County, Florida. The program is in its 15th year of operation and annually evaluates, without charge, 2,500 persons 65 years of age or older, and has examined 1,500 for more than 10 consecutive years.

The data collected as a result of the screening process is stored on a computer and evaluated in association with many outstanding scholars from some of the major institutions of higher learning in the United States.

The Florida Geriatric Research Program could be the prototype to be duplicated in multiple communities throughout the Nation. Although health evaluation programs have been conducted simultaneously in several areas in the past, they have been costly, not standardized, and restricted to shorter periods of observation. Ongoing evaluation of multiple elderly populations is a must and data and information gathering processes must be conducted. Then, and only then, will we be better equipped to reduce the burden of disease and disability in this age group.

Two, we feel an abbreviated health assessment, similar to that noted, at the time of entry into the Medicare system needs to be examined as a means of identifying immediate medical and psychosocial problems. If these are identified and addressed at a common time in the lives of the elderly, could not appropriate care result in an ideal preventative program for the entire elderly population? Would this not reduce morbidity, increase longevity and save dollars? We think they will.

[The prepared statement of Dr. Hale follows:]

THE FLORIDA GERIATRIC RESEARCH PROGRAM

MEDICAL DIRECTOR: WILLIAM E. HALE, M.D.

703 VIRGINIA STREET, DUNEDIN, FLORIDA 34698
(813) 734-6214 (813) 734-6216

Testimony: U.S. HOUSE OF REPRESENTATIVES

Select Committee On Aging

Subcommittee On Human Services

Chairman: Thomas J. Downey, New York

March 5, 1990

Clearwater, Florida

William E. Hale, M.D.

Medical Director

Florida Geriatric Research Program

National Advisory Board

William B. Applegate, M.D.
Chief, Division of Geriatric Medicine
Departments of Medicine and Community Medicine
University of Tennessee

George J. Caranasos, M.D.
Ruth S. Jewett, Professor of Medicine in Geriatrics
College of Medicine
University of Florida

William P. Castelli, M.D.
Director, Framingham Heart Study
Framingham, Massachusetts

Jennifer L. Kelsey, Ph.D.
Professor of Public Health (Epidemiology) and
Head, Division of Epidemiology
Columbia University Faculty of Medicine
School of Public Health

Marshal F. Folstein, M.D.
Eugene Meyer, III, Professor of
Psychiatry and Medicine
The John Hopkins Medical Institutions

Thomas F. Frist, Sr., M.D.
Chairman of the Board of Governors
Chief Medical Officer
Hospital Corporation of America

Mr. Chairman and members of the Select Committee on Aging, as the medical director of a 15 year longitudinal epidemiologic study of more than 5,000 over 65 year old persons, I am privileged to be able to participate in this hearing in regard to "Meeting the needs of the frail elderly: An oversight hearing."

In the few pages that follow, I will describe the need and provide some supporting information to justify the need for epidemiologic research such as that being conducted by the Florida Geriatric Research Program.

I am sure each of you is aware of the changing demographics of our nation and the emergence of the 85 year and older as the most rapidly growing segment. Even though life expectancy has increased and is expected to extend during the next 100 years, morbidity is increasing in this age group and there is an increasing need for hospitalizations due to acute illnesses or acute exacerbations of chronic illnesses.

Additionally, there are growing disabilities due to chronic disorders. All of these have a tendency to result in severe dependency which results in increasing need for managed care and nursing home confinement. The expenditure to provide care for all of these segments is also rising to astronomical levels. This is a societal problem germaine to every citizen and it must be addressed.

Many solutions to the problem of "old agism" have been proposed. Many have dealt with some form of restriction of services and resources. Yet, it has become clear that our society demands and insists upon economic security, physical well being and, yes, mental alertness. To solve any problem, all factors of the equation must become known quantities. Similarly, intelligent health policy requires obtaining data that monitors morbidity, disability, dependency, quality of life and factors, other than medical, to determine the trends as each person proceeds through the last years. **Thus, biomedical and epidemiologic research become important in developing perspectives and solutions.**

The medical literature about the elderly frequently contains comments such as, "There is almost no information about the primary and secondary prevention of disease using exercise when it is started in people past 75 years of age". (Gorman KM and Posner JD; Benefits of exercise in old age. Clinics in Geriatric Medicine, Vol 4, 1988) and "The recommendations for all nutrients other than energy, combine ages greater than 50 years into one group because there were insufficient data to make further distinctions." (Sutnick MR: Dietary guidance for the elderly. Clinics of Geriatric Medicine, Vol 4, 1988)

The list of diseases and disorders requiring increased investigation includes those commonly discussed in the popular literature of today: Alzheimers, osteoporosis, incontinence and many others. Too, nursing home care, although not a physical problem, because of its role in the future of the elderly must be mentioned.

Recent surveys have demonstrated the presence of Alzheimers Disease (AD) in 48% of those 85 years of age and older within the community. The cost of caring for 2 - 3 million persons with AD has been estimated to be $38 billion during the year 1983. If the projection of 16 million of our citizens reaching 85 years of age or older by 2050 holds true, our country could reasonably expect to spend $190 to $280 billion in caring for those affected.

It has been estimated that as many as 15 to 20 million persons in the United States have osteoporosis. About 1.3 million fractures attributable to this disorder occur annually. In 1980 there were approximately 200,000 persons with a medi[illegible]ge of 79 years that experienced hip fractures. The annual cost of all hip fractures exceeds $7 billion. The one year mortality is in excess of 20%.

Although not easily verified, 5 to 20% of elderly persons living in the community experience urinary incontinence. From 40 to 75% of those residing in long term facilities have the same problem. In the latter there is an increased incidence of pressure sores, indwelling catheters, and urinary tract infections. Too, indirectly, through embarassment, isolation, regression, and depression, this problem contributes to the decision to institutionalize more and more of the persons in this age group. There is no reasonably accurate method of estimating direct and indirect costs.

Nursing home care is currently being provided to approximately 1.1 million residents in this country. If predictions hold true, in the year 2050 there will be 8.5 million occupants and 5 million of these will be 85 years of age or older.

Mr. Chairman and Committee members, although the aforementioned represent only a small portion of those problems causing concern, the emotional, physical and monetary cost is staggering. **Efforts to improve the quality of old age and shorten the period of morbidity require an understanding that is not presently available from current data. It cannot, and should not, be assumed that there is little to be gained by conducting biomedical and epidemiologic research directed to this age group.**

There is an overwhelming need to examine existing data and to continue to gather information that lets us better understand the physiologic and psychosociologic processes in the 85 year old and older. One approach to this process is typified by the Florida Geriatric Research Program, a longitudinal epidemiologic study of the ambulatory elderly, being conducted in Pinellas County, Florida.

The Florida Geriatric Research Program is in its 15th year of operation and annually evaluates, without charge, 2,000 to 2,500 persons 65 years of age or older, 1,000 for more than 10 years). From the time of its inception, over 5,700 persons have been enrolled. The results of each evaluation are given to the individual participant and they are urged to see their physician about any abnormal findings.

The data collected as a result of the screening process is stored on computer and evaluated in association with outstanding scholars from some of the major institutions of higher learning. These include the University of Florida, Johns Hopkins, Columbia, Harvard, Louisiana State University, Northwestern and others. To date, utilizing the data, fifty (50) papers about a variety of medical topics have been published in the medical literature and circulated throughout the world. Too, the Program vigorously supports educational efforts to promote better health care in this age group.

The Florida Geriatric Research Program could be the prototype to be duplicated in multiple communities throughout the nation. Although health evaluation programs have been conducted simultaneously in several areas in the past, they have been costly, not standardized, and restricted to shorter periods of observation. **Ongoing evaluation of multiple elderly populations is a must as a data and information gathering process.** Then, and only then will we be better equipped to reduce the burden of disease and disability in this age group.

Too, an abbreviated health assessment, similar to that noted, at the time of entry into the Medicare system needs to be examined as a means of identifying immediate medical and psychosocial problems. If these are identified and addressed at a common time in the lives of the elderly, could not appropriate care result in an ideal preventive program for the entire elderly population? Would this reduce morbidity, increase longevity, and save dollars?

William E. Hale, M.D.

Mr. DOWNEY. Thank you, Doctor Hale.

Doctor Hale, let me begin with you, and let me just start on that last point. You are suggesting that at age 65, in qualifying for Medicare, that there be a medical and psychological evaluation done?

Mr. HALE. Congressman, we have, for 15 years, and we proposed it at that time, we felt that some type of superficial health evaluation, both medical and psychosocial perspectives, could be conducted, relatively inexpensively, and I feel it could be an ideal preventative program to, really, impact the future of this age group, without a doubt.

Mr. DOWNEY. What else? You have done research now for 15 years. What other information can you share with us on the health promotion strategies which would help the frail elderly? Are there other things that we should be looking at and doing that we are not doing now—or attempt—that we should be augmenting?

Mr. HALE. Congressman, I feel that the volunteers that we have typically in this community add a dimension that reduces the financial obligation for conducting studies such as we are doing. I think you would be amazed and be surprised at how economically we see 2,500 people every year, and it is principally because we are recruiting people who are interested, people in this age group that want to be a part of this type of evaluation, and I think it needs to be encouraged.

Similarly I think there is a great need for education in regards to preventive medicine.

Mr. DOWNEY. Let me ask you, where does your funding come from for the Florida Geriatric—

Mr. HALE. We are not sure sometimes, Congressman. No, very seriously, from contributions. Private contributions, some corporate support.

Mr. DOWNEY. Does the State provide any money?

Mr. HALE. The State does not provide any funding, no, sir.

Mr. DOWNEY. And the Federal Government provides no funding?

Mr. HALE. Federal Government has not providing any at this time, no, sir.

Mr. DOWNEY. What sort of relationship do you have with Doctor Butler in New York and other groups that—

Mr. HALE. We have not related with Doctor Butler specifically, but we do have a relationship with a group in the public health sector from Johns Hopkins. We have worked just recently with a group representing the Harvard community. Also with a group from Northwestern and from LSU and other major institutions. And there have been efforts that have been focused for their specific areas of interest. The one with Hopkins has been directed toward cardiovascular disease in this age group. As you know and I know, very typically, that there is a question of, is cholesterol important in older people, and I think the medical community has some tendency to say, well no, that is not true, that has not been verified. Another area of extreme interest is, I think that everybody says that exercise is a valid program for the elderly to help prevent osteoporosis, common perception, but we are not sure that that is true, and we need to look at those issues and to be able to say, yes, you are 80 or you are 85. Exercise can help keep you from

having fractures, or do not. And those are small focuses, but that is the type of thing we are talking about.

Mr. DOWNEY. And you are satisfied that what you do here and what you learn here is shared with others throughout the country?

Mr. HALE. We would like for it to be shared more. As I say, we are interacting with multiple institutions, but it has been because of areas that they have a focused interest in and have approached us to be a part of their objective and their strategy. We would like to have more exposure. We have written approximately 50 articles that have appeared in medical literature, and we get requests from all over the world, Congressman, for copies of what we have written about.

Mr. DOWNEY. Thank you.

Mr. HALE. Thank you, sir.

Mr. DOWNEY. Doctor Polivka, can you give me an idea whether or not Florida has a State run or State funded case management program for the frail elderly?

Dr. POLIVKA. Yes. As part of our community care for the elderly program that Senator Kiser and Ms. Palmer mentioned this morning, we provide case management, and I think we have developed through that program, and particularly in Pinellas County, Pasco, some really model case management approaches. So yes, it is included, but again, as part of a lack of funding problem, we have caseloads for the most part that really exceed what they should. We are talking about caseloads of 100 to 1 rather than 60 to 1, which really dilutes the effectiveness of the program.

Mr. DOWNEY. There is no legal impediment then for Florida, under the Older Americans Act, for Florida having its own money?

Mr. POLIVKA. No, it is just that we could use more, and I think, as I said, that that is a crucial kind of linchpin service that should be a part of the OAA.

Mr. DOWNEY. And I am going to ask the same question of Ms. Duggar and Senator Kiser, there is also no doubt in your mind that the problem here is money? I mean, if we had more we would be able to do more.

Mr. POLIVKA. That fact is, based on the experience in this State for the last 15 to 20 years, we know how—and this is true not just here, but in other parts of the country—how to provide community services that are true, effective alternatives to institutionalization, no matter what HCFA may say, based on our channeling experience that was far too limited. Look at our community care for the elderly. Look at experiences in Oregon, and you will see how we can provide cost effective alternatives that people prefer.

Mr. DOWNEY. I am delighted to hear that, frankly, and you say it with confidence, and I have no reason to doubt you. When we get back, we will try and make sure that HCFA takes a little different look at that. I will talk with Mr. Stark about this because from what I have seen and from what you have told me, we might need to make some changes.

Ms. Duggar, you mentioned in the 1987 evaluation of the Community Care for the Elderly Program, which was done by the Florida auditor general, was this a public document?

Ms. DUGGAR. This is a public document, Congressman.

Mr. DOWNEY. And would you provide that for the record?

Ms. DUGGAR. Be pleased to do that. It addresses your previous point very effectively.

Mr. DOWNEY. Yes. Thank you.

[See Appendix, p.75 for subject material.]

Senator Kiser, let me ask you a political question. What support is there in the Florida legislature for expanding programs to the elderly?

Mr. KISER. Well, I think there is a great deal of support. As a matter of fact, when we made mention of the lawsuit, the immediate effect of that lawsuit and that judge's decision was that this county was going to receive a substantial cut, which boiled down to, of the five adult day care centers, we were going to be cut down to only four, and the one that was going to be eliminated was in my district.

Mr. DOWNEY. That is a crisis.

Mr. KISER. Exactly. That is one of those personal problems. So immediately we started digging into what we needed to do to try to keep that center open because, as you will hear hopefully from some of the people who are in the audience today who directly benefit from the services of that adult day care center, we had to figure out some way to keep that open. So we had a separate line item in the budget to restore with State monies the lost Federal funds that were now going to be redirected to Miami, and the unfortunate part about that was, they have not even spent all the money down there, and yet, we have waiting lists here. We have waiting lists of people who cannot get in. So we cannot—we were not even using—we had more need than what we already had, and then we were going to lose that money. So when we got that issue known to the legislature, it really was not too much of a problem getting that money restored. So we had to supplement that with State money to replenish what was now being sent to Dade County. So I think when those people could see that it directly relates to some of those programs, an immediate benefit to their communities and their constituents, there is support for that. One of our concerns, however, was once we appropriated that State money, we still had the lingering concern that somehow the Federal court may still reach out there and say, "No, no, you cannot do that. That also goes to Dade County." So we would want to be sure that any Federal legislation is very clear that if the State chooses to supplement that, that they can do so with their own formulas.

Mr. DOWNEY. Excellent point.

Mr. BILIRAKIS. Thank you, Mr. Chairman, and I thank the panel. These good people, Ms. Duggar and Doctor Polivka, for the benefit of those in the audience, have come down here from Tallahassee for this hearing. Obviously they are experts in the field. Doctor Hale, what can anybody say about him? If you read the newspapers around here, you know that he is one of the most honored individuals in the area, not only for his work in geriatrics, but—Doctor Hale, I do not mean to embarrass you, but because of illness had to in effect give up his medical practice, and rather than to—forgive me, Bill, I hope I am not embarrassing you, but rather than to just sort of sit back and retire, if you will, and enjoy life, he is giving much more than he is receiving. He has decided to be even more active than ever in so many different ways, and he is just one of

those wonderful individuals. It would be a much better world if we had more Bill Hales.

And you deserve that, Bill. And Senator Kiser is my State senator and Palm Harbor is also not only in my district but where I live and where he lives also, I might add. And he was one of those initiating forces as far as this problem is concerned, and I have always appreciated working with Curt and this is why we did not hesitate to ask you to serve on this panel.

Much has been made, started by Congressman Bill Young in his opening remarks, on the issue of home health care. You know, it is almost a—not almost, I guess it is a pay me now or pay me later type proposition. Doctor Polivka and Ms. Duggar certainly set it out very well, and maybe we can concentrate on that, but before I forget, I also want to emphasize Senator Kiser's points. I had heard during the time this crisis first appeared that the people in Miami had not been using, or were not using, all the funds that were allocated to them, and I think the next panel probably will hopefully—Fred, Sally and some of the others will verify that. In spite of all that, we are still not talking in any way whatsoever of taking any funds away from them. Somebody in their wisdom decided that so much would go to Miami for good reasons, I am sure, and consequently in spite of the fact that they maybe had not been using the funding back at that time—I do not really know what it looks like now—we still are not attempting to take any money away from those people, and I know Senator Kiser feels the same way about it all. We are just talking about additional funding as a result of cranking the frail elderly into the formula, if you will, and that is something that the Congress has to do, and I have talked to Congressman Downey about that, and he immediately picked up and recommended a hearing, which I am very grateful for.

Getting back to home health care, Ms. Duggar, you cite in your cost analysis that nursing home eligible persons are being served in their homes for 20 to 25 percent of the Medicaid cost of nursing home care. Does this ratio factor in the cost of food and shelter for individuals being cared for at home?

Ms. DUGGAR. No, sir, that does not. That is the cost of care to public funding sources, but that does come from that independent study of the auditor general. Now, I would want to clarify for the committee that the success of the Florida's Community Care for the Elderly program is in part based on the fact that it is not just home health care, but it includes that full array of services beginning with case management and accurate assessment of the individual and all of the resources that they have to bring to the situation, but it also includes medical transportation, homemaker services, home delivered meals, and very, very important respite care for the caregiver.

Mr. BILIRAKIS. So you have set out for us, really, some pretty comprehensive range of services that we are talking about here.

Ms. DUGGAR. It is. And I think that is critical to the success—

Mr. BILIRAKIS. Now, as far as case management is concerned, are we affording most of it at the facilities, or is some of it being afforded at the home as a result of home health care, if you will, or is it better done at the home if more funding were available? I might ask you and Doctor Polivka that question.

Ms. DUGGAR. Yes. The majority of case management is done in the home because you need to look at the overall environment. Occasionally it is done in a facility like an adult day care facility, but the best case management includes the home environment.

Dr. POLIVKA. I think that that is the most appropriate arrangement. However, when you have caseloads the size we are talking about sometimes the only way you can faithfully get in touch with people is through some kind of facility based interaction. That is not the way it should be done though. We should be much more flexible and more of it—most of it should occur within the home.

Mr. BILIRAKIS. I have had occasion to visit fairly often a number of the congregate eating facilities, and what I see is not only furnishing these good people nutritious meals, but I see an intangible there. I guess I am going to call it intangible. I guess because I am talking psychological, if you will, mental benefit, and it maybe speaks more towards Doctor Hale's comment, but the point—I am going to use the term "fraternalism" for lack of a better word, but the fact that they have something to look forward to, the fact that they come into those facilities and see virtually the same people every day rather than sitting at home all by themselves. Meals on Wheels is a great program, and my wife used to be involved in that, but again, it is just not the same thing as being with other people roughly in your same age bracket, and that is being reduced, is it not? I believe Doctor Polivka made the comment—one of you made the comment—that there was a shifting of dollars, Curt? Was there a shifting of dollars from that program?

Mr. KISER. Yes. In an effort to meet the needs of a growing frail population, that is, over 85, we have had to provide more meals in the home, and when the pie is, in effect, not only not growing, but given the increased cost of living, shrinking, that means that there are simply fewer dollars for the congregate meal program, and I agree with you entirely, Congressman, that there is a communal spirit involved in the congregate program that really, I think, adds a spark to the lives of many people, particularly in Florida because, frankly, while we have many families involved with our older people here, there are a lot of people in Florida that have moved from other places and do not have that family network so that the congregate meal program is really important to them in terms of having any kind of community life at all and to the extent that we have to reduce it is a real problem.

Mr. BILIRAKIS. You may not have these figures right at the tip of your head, but how much of the cost of that program is self-generated—I know that there is a basket or something at the door when people come in and there are contributions made by many, many of the people. Some do, some do not. Quite frankly, there are quite a few that go who can afford to contribute who do not. We all know that, but that is, I guess, maybe human nature, but how much of those contributions that come from the people who use the program actually goes towards paying for the program? A very small amount?

Dr. POLIVKA. We do not have any exact number on that, or amount. Maybe some of the folks from Pinellas/Pasco have some estimates on their own programs. I understand that it varies, but it is pretty small.

Mr. BILIRAKIS. It is pretty small.

Dr. POLIVKA. Yes, Margaret Lynn just suggested that 10 to 15 percent would be—

Mr. BILIRAKIS. Can that be improved in any way, do you think? Have you given any thought to that?

Dr. POLIVKA. Well, we have been dealing with a fee issue for awhile, and I think that based on a survey that we have done of our area agencies in Florida, most of them feel that there should be—you should look very carefully in allowing fees or expansion of fees. I am not sure that you are going to get any more through fees than you get through current donations. I am just not sure. I am still looking at that. We are looking at it. But Margaret Lynn, I think—

Ms. DUGGAR. Congressman, I think one of the issues is that you are looking at a population that has increasing frailty and a very modest income typically, and so the contributions that they are making often times—part of my background, as you know, was as director of one of those programs for 6 years. Many people are in fact trying to support the program to the extent that they are probably giving a larger share than they should, given their other household and utilities, medical expenses.

Mr. BILIRAKIS. We certainly do not want that.

Ms. DUGGAR. No. But I think that 10 to 15 percent of the statewide, that budget, is met through contributions, which go directly to expand the program itself. No administration, no reverting to government in any way, and I think that is a sizable amount. We are talking a little over $5 million a year in this State, and the same is true with community care for the elderly, but many people who do not—when you talked about people who do not give, I have often known people to send a check to the office, or to use food stamps, which they were embarrassed to use publicly. So the fact that you do not see them giving at the site does not mean that they are not, or their families are not, making a contribution through the mail, or another mechanism.

Mr. BILIRAKIS. And you know the elderly who work in these facilities—

Ms. DUGGAR. Tremendous contribution.

Mr. BILIRAKIS. —tremendous contribution. Many of them, of course, volunteer. Mr. Cavo, I understand, at age 80 is a volunteer and something that he should be commended for, but these good people get actually, as I said about Doctor Hale, they gain more than they give when it comes to these programs because of their volunteering and, of course, the fact that many of them work, certainly not for very much money, but it is a Godsend for them to be kept active.

Doctor Hale, in your testimony you discussed some of the more critical diseases and disorders affecting the elderly. Is your program developing any particular findings on these and other diseases, and I might also ask, is your program in a position to work with area agencies on aging and other organizations for health promotion and management of chronic diseases of the elderly? Do you work together in many ways?

Dr. HALE. Congressman, before I answer your question, I would like to thank you for your kind comments. I was somewhat embarrassed by them, but I thank you very much.

Certainly as far as dementia, and that specific area that you are alluding to, we have just finished a project with a group from Harvard examining the cognitive functioning of 300 over 65 year old individuals in the age range of 65 to 74. They are applying for a grant to extend that beginning possibly in January of next year working with us and to look at a much broader segment, that is, the older, frail segment that we are talking about today to try and identify cognitive functioning to see if there is some other mechanisms that might be instituted to help slow that process down, and there is some indication that this may be true. What was the second part of your question? I am sorry.

Mr. BILIRAKIS. Well, the interrelationship, if you will, with other aging organizations.

Dr. HALE. We welcome the opportunity to work with other aging organizations from government to institutions of higher learning to students, et cetera, to try and share our information. Our thrust is to try and help the people in this age group and what is necessary to do, we will try and do, sir.

Mr. BILIRAKIS. The psychological evaluation you mentioned in response to Chairman Downey's question, how would you—if you were king, let us say, and were able to put that into effect to the extent that you would like to see it put into effect, how would you see that working? What do we say, as soon as a person turns 65 it is a mandatory thing that you have to go and be evaluated? How would you suggest this be done, if in fact it could be put into effect?

Dr. HALE. Congressman, I would think that at the time the person enters the Medicare process, it would not be unreasonable to provide a questionnaire of, say, 150 to 200 well selected questions that have been arrived at jointly with some people far more knowledgeable than I am about questionnaires, et cetera, but we would be happy to share our input. But to develop a questionnaire that would focus on the issues that we are talking about, both medically and psychosocially as well, and to give that to the person as they, quote, sign up for Medicare. And then also request that they go to their local hospital and have some basic evaluations done. I am talking about some very basic blood tests. I am talking about electrocardiograms, some very basic studies. Not the extensive process that we think of when we go through a health screening, but some that will indicate problems that can be addressed and can be taken care of before the patient or before the person enters the process where he is going to be depending on others for acute care. If we can help keep people out of the hospital and help decrease the morbidity and help them remain active for a much longer period, then I think we have accomplished what we are all trying to do, sir.

Mr. BILIRAKIS. Part of the preventative, wellness care program?

Dr. HALE. Yes, sir.

Mr. DOWNEY. Mike, would you yield on that?

Mr. BILIRAKIS. By all means, sir.

Mr. DOWNEY. Doctor, this is a very intriguing idea. Let us assume one found something out. How would you then translate the information that you have, whether it is psychological or physi-

ological, to implement a change. Obviously, there would be a consultation with the patient, but who else would you share that information?

Mr. HALE. Congressman, in our program we do not personally refer or become involved in the treatment of any individual that comes through our program, but we have become very insistent that they seek medical care, and it is not a focused referral, but we generically say, "You need to see a physician," if they do not have a physician. If they have a physician, then we welcome the opportunity to share the information we have collected with that physician, and most of the people at that time, if they have some abnormality pointed out to them, that would be addressed and taken care of. If not, they will be introduced into the health care system at some point.

Mr. BILIRAKIS. I have nothing further, Mr. Chairman. Again, my thanks to the panel.

Mr. YOUNG. Mr. Chairman, I think you have been impressed already with the witnesses and the contributions they are making to the issue that we address today.

Quite a lot of emphasis has been placed by all of you on the issue of funding. Obviously, any program we are talking about is going to require money. I have the privilege of working on the Appropriations Committee and on the subcommittee that handles the funding for all of our health programs and education programs. Chairman Downey has the distinction of working on the Ways and Means Committee. They are the ones that have to raise the money, but in the end, it is all of you sitting out there and people like you all over America who finally come up with the money that I spend and he raises. But we all recognize this, that these programs are expensive and they are going to require funding, and now, Senator Kiser—we are working with the University of South Florida right now to help them be funded as part of an ongoing Federal program to do specific research on aging in Florida, and I am assuming that you are going to take care of the funding for the State's part of that through the university system, and I know that you will because I know of your strong commitment to this.

But when we talk about funding, and several of you mentioned this phrase, "funding formulas", Florida does not always come out in a real strong position when these formulas are applied, and I think one of the reasons is that many of our colleagues on a day-to-day basis do not—are not faced with the issues of a growing elderly population. Many of them, as their constituents grow older, they see them retire to Florida, bringing with them whatever needs they might have as they grow older. But I would like to ask a specific question now, and Senator Kiser—in fact, all of you have mentioned this and touched on it, but say something about the situation in Florida where people actually maintain their permanent residence in another State, but spend most of their time in Florida and get their health care in Florida, but when they are counted for the formulas, they are counted in some other State. They get the benefit of that person's residency, but we get the requirement to take care of their needs. Comment on that. To what extent does that become a problem for Florida?

Mr. KISER. Well, Congressman Young, there is no question that you are absolutely right that on these funding formulas—as a sideline perhaps maybe whatever new formula is struck may be done after the next census election, and then all the States in the Sunbelt States are going to feel the pressure of these retirees from the Midwest and Northeast coming into our State and with them bringing, in many cases, their health care problems with them. I also happen to serve in another capacity and that is as the Chairman of the Special Committee of Mobile Home Owners and their problems. And you find, for example, in mobile home parks, many times as you drive around here in the summer months, at least in many of the retiree parks, which is the majority of them, half to two-thirds have gone back home over the summer months to their original home and then come to Florida for the winter months. There is no question that somehow or other there needs to be a factor put in that equation that will build into it, and we have a chart that I want to leave with the committee that shows the build-up of the over 85 population both at the country level and then at the State of Florida level. You will see that is it much more dramatic in Florida. So I would urge you to take into consideration that percentage increase and somehow or other factor that in there because there is no question, Congressman, we are going to be feeling the brunt of the people that leave—people like Congressman Downey's district and come down here either on a full or part-time basis, and at some point it does become full time, and I cannot—I wish I could give you a statistic, which I do not have one, that would show you clearly that direct impact. The only thing I can give you is, like I say, if you were to look at the mobile home parks, you will see in those cases, those people are here in big numbers, and, again, in the summer months, half to two-thirds of those parks are empty with those people being back up north.

Mr. BILIRAKIS. Will the gentleman yield a minute?

Mr. YOUNG. Of course.

Mr. BILIRAKIS. Curt and, Bill, I also wanted to—you mentioned mobile home parks. As you know, I also serve on the Veterans' Committee, and the Veterans' facilities have the same problem, Tom. The facilities up north, certainly in the winter, and maybe even year long, their occupancy rate is usually pretty darn low, when we have people standing in line down here, and our funding comes as a result of population, if you will, when in fact our population balloons, particularly during those winter months, and, of course, we also have to take into consideration the vacations. We are just talking very fondly when we refer to the snowbirds and what it does to our facilities here, and they are veterans also, and they have every right to use our facilities here, but from a funding standpoint, it is completely cockeyed. So it is an issue that I appreciate very much Bill bringing that up and Tom is here to hear it. It is an area that we, again, do not want to take away from someplace else, but at the same time, we are just not being fairly dealt with. Thanks. I appreciate the gentleman yielding.

Mr. YOUNG. Ms. Duggar, you work a lot with folks who fit into that category. Do you have any comments for us on that?

Ms. DUGGAR. It is a major issue in planning and budgeting for our programs. I would also like to suggest with April 1st being the

day of the census, we had tried through a number of vehicles in Florida to strategize in order for people to be registered here, and I understand from census regulations that that kind of advocacy is not encouraged.

Mr. YOUNG. Well, on a similar subject, in some of the other parts of the country that we are talking about, as folks get older, their children or their grandchildren tend to help a lot—help with the home health care. For example, Mr. Cavo's case, if he had some children here or some grandchildren, they might be able to give him a break and to help care for his wife, but here in Florida, an awful lot of folks come and retire here while their children remain behind in the home State. Tell us how much this affects the care of the elderly.

Dr. POLIVKA. Well, as I mentioned, over a period of time—particularly, I think, during the 1990s, we are going to see an increased dependency on public programs, but I can assure you, as far as Florida is concerned, and this is a cue that we are really taking from the legislature as much as any place else, we are going to build our programs on that informal system wherever it exists. Our whole objective will be to strengthen family, friends, networks, folks like this out in the community so that they can do as much of the job themselves, but I think inevitably in Florida it is going to mean an increased demand for public funding for community programs. I think that is an inevitable event.

Ms. DUGGAR. I would like to address that. The community care for the elderly program several years ago did a study on caregiver stress, and there were some remarkable findings in that study. So while it is important to rely on family and friends for that kind of support, the community programs that have been funded by the Florida legislature and by the Older American Act, greatly enhance a caregiver's ability to provide that service. That study showed that with some minimal level of support, such as respite care and direction towards community base services, that the caregivers in that study not only had reduced their stress level from just prior to services beginning until a year later, after they had been giving care for an additional year, but they also gave more hours per week of care and provided additional financial support. So the community based programs that you are addressing, greatly impact the ability of those caregivers to provide that sort of support in a very positive and measurable way.

Mr. YOUNG. Yes, Doctor?

Dr. POLIVKA. That is an excellent point. I think it deserves reinforcing. The fact is that 80 percent of the long-term care in this country is provided by families and friends in the community, not through the public sector. The average family will sustain an older relative up to 6½ years before they will even consider institutionalization. The data that Margaret Lynn is talking about indicates that with these kinds of other services most families will take care of their older relatives until the very end, and that is precisely the kind of care that the older people overwhelmingly prefer themselves.

Mr. YOUNG. The programs that we have here, Mr. Chairman, I think would serve well as a model for the rest of the country in providing this type care because it is done very well here, and you

are going to hear from the next panel some of the folks that do that.

I thank you very much for your comments, and be sure that your comments will be shared with our colleagues in Washington in order to help confirm the proposals that Congressman Bilirakis and I have been making year after year. Thank you very much.

Thank you, Mr. Chairman.

Dr. POLIVKA. Mr. Chairman, if I could make one more statement, please.

Mr. DOWNEY. Absolutely.

Dr. POLIVKA. Thank you. I would like to bring it to your attention—I think I speak for most people, certainly in Florida, and most people I talk to, that the intergenerational conflict notion is—is bogus. As far as the people of Florida is concerned, we consider this a family issue, and you cannot raise the—or emphasize the needs of one part of the population at the expense of another because you are dealing with a family, in each case, from one end of the age spectrum to the other. That has to be kept in perspective, and we are very concerned about that.

Mr. DOWNEY. Can I ask one final question? You indicated that 80 percent of the people who receive care get it by the family and that 6½ years is the principal duration before you consider—have you done any studies, or do you know of any, that quantify exactly how much money is saved by this process of home care versus institutionalization?

Dr. POLIVKA. Well, we are in the process of doing that analysis now, my staff in Tallahassee, and we are going—cooperatively with the Pepper Commission that Senator Kiser chairs, and what we are looking at is experience of other States. We will pull that information together over the next couple of months. As a matter of fact, we are developing it as a part of a waiver request to HCFA to begin to move more dollars from the Medicaid institutional program into the community programs, and it is our objective to pull that together in a coherent presentation to demonstrate its effectiveness. We know for instance, as Margaret Lynn mentioned, in Florida, a conservative estimate is that one-third of the people in a community care program would be in an institution if they were not in community care, and we know that community care costs approximately $1,500 a year compared to $20,000 in a nursing home. We now have a new program that the legislature funded last year called Project Diversion. That spends approximately $4,400 a year. Our early indications are that it is diverting even the most seriously at-risk people from institutions, the most disabled. And we know from experience in Oregon that they were able to reduce their nursing home admission rates from 6 percent of the over 65 population to under 3.3 percent in 7 years through a comprehensive waiver that allowed them to increase their community programs by threefold in 7 years. Those are important experiences that we think have dramatic implications for the future of long-term care in this country. We will be pulling that together.

Mr. DOWNEY. That is excellent.

Mr. BILIRAKIS. Excuse me, Mr. Chairman. Would you furnish a copy of that, please, to the committee?

Dr. POLIVKA. Certainly.

Mr. BILIRAKIS. I would certainly like one in my office too, but I am sure it would help the committee.

Mr. Chairman, may I ask very quickly—what can, or what should, Congress do, if anything, to encourage more family involvement? Now the 80 percent figure impresses me. I am very pleased to hear that because I kind of have the feeling that we are getting away from where the families, the children and the grandchildren taking care of the elderly. So I am very impressed with that, but obviously there is a 20 percent figure there. Now maybe none of that 20 percent could or would be taken care of by the families. Maybe all that 20 percent would be depending on other types of care, but is there a portion of that possibly—could the Congress do something, you know—Tom has to worry about raising the money, tax credits, things of that nature that might encourage a little bit more of that?

Ms. DUGGAR. Congressman, I would love to answer that. The dilemma for families is that the community based programs are not an entitlement, the way Medicaid nursing home is an entitlement. Addressing this issue through HCFA in terms of valuing a community based alternative equally with institutional care is precisely what Congress needs to do. The dilemma is that we talked about the funding needs, and earlier a person referenced the waiting list, which are tragic in our State, and in many States across this Nation, and so the Older Americans Act has limits. It is obviously not an entitlement program. Our community care for the elderly program, which now just about exceeds the Older Americans Act dollars in this State, is not an entitlement. So people have to be put on waiting lists for those services. The only thing that they can get access to is the nursing home when in fact we know it is more cost effective in terms of the public dollars and it also meets people's preferences for independence in choice to stay in the community, but the HCFA approach for financing only leaves them one option and that is the nursing home.

Dr. POLIVKA. That is one of the things you are going to hear as you pursue this issue, particularly with HCFA, I think. And it is not as if we want to cast ourselves totally in opposition to HCFA policy or approach. It is simply that they were, we think, overly impressed by what was called the channeling project in its evaluation that showed that according to HCFA's interpretation that it wasn't diverting people from institutions, it was simply providing more community services for people who were already in the community with their families and would not have been in an institution. The quality of their lives were improved, but they were not diverted from institutions. Our approach is that when you take a systematic comprehensive program like CCE in Florida, or a State system as in Oregon, you can get those cost savings because you have a complete program, not a program in isolation, which channeling was largely across this country. So as you deal with HCFA, please be mindful of the fact that there are all these other experiences out there in the States that we think you should draw on in setting long-term care policy for this country, not one single evaluation of one single program.

Dr. HALE. May I make a comment? In closing, the focus has been in regard to morbidity and home health care, in the care of the el-

derly, we continue to maintain that if there is the possibility that period of morbidity and disability can be decreased by better medical care and better preventative medicine, then we think that ought to be accomplished. We conduct our program on an annual budget that is probably equal to a figure that we estimate to be the cost of keeping one person in an intensive care unit for a period of 3 months that we can run our entire program for those funds. We feel that thrusts like this are absolutely necessary. We feel too that an evaluation needs to be conducted to see if indeed our program is accomplishing what we think it is. Is it decreasing morbidity? Is it keeping people well for longer periods? And we think that other prototypes need to be established, and as always, we could use support too.

Mr. DOWNEY. Well, let me just, on behalf of my colleagues, thank you for a very impressive testimony that has been very useful to us. I think that Mike and Bill and myself will be taking some of your ideas back to Washington because they have been very, very helpful. Thank you.

Mr. DOWNEY. The subcommittee will next hear from Sally Gronda who is the Director of Area Agency on Aging, Division of Tampa Bay Regional Planning Council; Frederic Buchholtz, who is the Executive Director of Neighborly Senior Services, Incorporated, and Bill Aycrigg, who is the Assistant Executive Officer of the Community Aging and Retirement Services, Incorporated.

As Congressman Young mentioned, the other committee on which I serve is called the Ways and Means Committee, and we raise taxes, or lower them. We also have the responsibility for Social Security. And let me just say, it is a lot easier to spend the money than it is to raise it, and one other point, most of the New Yorkers who are in the audience, my guess is they have changed their residence to Florida. They much prefer not to have State income tax to pay than to have the pleasure of being New York residents and paying State income taxes. So we may not be the people escaping being counted.

Ms. Gronda, if you would begin.

PANEL THREE, CONSISTING OF SALLY GRONDA, DIRECTOR, AREA AGENCY ON AGING, DIVISION OF TAMPA BAY REGIONAL PLANNING COUNCIL; FREDERIC BUCHHOLTZ, EXECUTIVE DIRECTOR, NEIGHBORLY SENIOR SERVICES, INC., PINEALLAS COUNTY, FLORIDA; AND JOHN L. SNIEZEK, JR., CHIEF EXECUTIVE OFFICER, COMMUNITY AGING AND RETIREMENT SERVICES, INC., NEW PORT RICHEY, FLORIDA PRESENTED BY BILL AYCRIGG, EXECUTIVE DIRECTOR, COMMUNITY AGING AND RETIREMENT SERVICES

STATEMENT OF SALLY GRONDA

Ms. GRONDA. Congressman Downey, Congressman Bilirakis, and Congressman Young, we welcome you, and I appreciate this opportunity to comment. My name is Sally Gronda. I am the Director of the Area Agency on Aging which covers Pasco and Pinellas Counties. I am very pleased to have this opportunity to address you regarding a topic of utmost concern to those of us who work with and for the elderly, that being the plight of the population over the age

of 85, the so-called "frail" or "at risk" elderly. By the way, I am pretty much going to sound like a broken record from the previous panel.

The National Council on Aging has defined "at risk" as those older persons with physical, mental or emotional conditions that may handicap their functioning capability or their ability to fully care for themselves. The frail elderly, usually thought of as being "at risk" are also usually considered to be the 85 plus segment of the population. This is the fastest growing group in the country and, I might add as a point of interest for this committee, that Pasco and Pinellas Counties rank number one in the entire State of Florida with 85 plus population. It is around about 19 percent of all people over the age of 85 live in Pasco and Pinellas Counties.

The United States Statistical Abstract for 1989 states that Florida ranks number one in the country as far as persons over the age of 65 also.

Therefore it is natural that we would have a special concern for this problem. Today Florida's population redistribution is what the rest of the country will be facing in about 30 years. So this is a very real concern for the entire country.

Let us compare the service needs of the various strata of elderly. At 60 years of age, about 5 percent need supportive services. At 75, it is anticipated that 15 percent will need supportive services, and at 85 it drastically jumps up to 50 percent of those people will need some kind of assistance, and this is information from the National Institute on Aging.

Clearly the responsibility for the care of the 85 plus population rests with both the families involved and the government. As more people live longer, their caregivers, whether they be siblings, sons, daughters, nieces, or nephews, will be older also. We have persons in their sixties and seventies who may have health and financial problems of their own providing care to their parents.

Traditionally—I thought this information might be of interest to the committee—traditionally, women have been primary caregivers of older residents. Four social trends, however, are having an effect on this role. Number one, the increasing divorce rate is creating fragmented and redefined families. Number two, the changing characteristics of the older population are requiring caregivers to possess new coping skills. Number three, the current geographic mobility of the population is creating the need for long distance—I put in quotes, "caregiving networks". Fourth, and probably the most important, the spiraling number of women in the working world are forcing a redefinition of the caregiver role. Such a redefinition addresses both the family and the workplace as a new source of support and information in caring for older relatives.

It is the time to begin the plan for the reauthorization of the Older Americans Act in 1991. I will have to say that I am one of the Area Agencies on Aging that Doctor Polivka mentioned that do not agree with a fee system. So I wanted to make this point during this hearing that I strongly oppose any kinds of means testing or a fee system for the Older Americans Act. The Older Americans Act was not designed in its inception in 1965 to be a welfare program and that is exactly what would turn the Older Americans Act into a welfare program should a means test be mandatory. I strongly

urge that we retain the volunteer contribution. And in the testimony that came out earlier—I really do not think that we are going to generate more income for means testing. We are going to create—put people in a situation where they will not come to these programs because they are going to see it in a totally different light. Also at the local level, we are going to have to develop a system like our State community care for the elderly program of billing. That is more administrative costs and totally unnecessary in my opinion.

Let me quickly get back to the reauthorization and then I will wind this up. We applaud the 1987 amendments that created Title III D. It is a very important step forward for the frail elderly. As mentioned before, we do need more money, not just for D, but for B and C Titles of the Older Americans Act.

Our funded projects in Pasco and Pinellas Counties are taking great care to do effective outreach and are developing innovative ways to target minority and below poverty level clients. We are receiving detailed monitoring of these individuals. So again, we are grateful for this strengthening, but it is not enough. We do not want to take away from any one segment of this population. What we are proposing is that the focus on the 85 plus fee, added as another special needs category, just as has been mentioned several times by other people giving testimony here today.

Insufficient attention has been paid to the results of the combination of losses suffered by the 85 plus population. I would certainly encourage that this be built into the Older Americans Act as another group under Title B and C. Title D already does address the frail elderly, but we do need to target the meal sites, home delivered meals, day care centers towards those very frail elderly.

We strongly urge the passage of the bill sponsored by Congressman Bilirakis and Congressman Young. H.R. 1879, we think this is an effective opportunity to channel more money into Florida, all of Florida, not just our area.

In consideration—I have already mentioned that. I guess at this point, I will just thank the committee, and I will be happy to answer any questions later.

[The prepared statement of Ms. Gronda follows:]

tampa bay regional planning council

9455 Koger Boulevard
St. Petersburg, FL 33702-2491
(813) 577-5151/Tampa 224-9380
Suncom 586-3217

Officers
Chairman
Commissioner Patricia Glass
Vice Chairman
Commissioner Mike Wells
Secretary/Treasurer
C. Coleman Stipanovich
Executive Director
Julia E. Greene

Congressman Downey, Congresswoman Snowe and members of the House Select Committee on Aging, we welcome you to Pinellas County. I am Sally Gronda, Director of the Area Agency on Aging of the Tampa Bay Regional Planning Council. I am very pleased to have the opportunity to address you regarding a topic of utmost concern to those of us who work with and for the elderly: that of the plight of the population over the age of 85, the so-called "frail" or "at risk" elderly.

The National Council on Aging has defined "at risk" as those older persons with physical, mental or emotional conditions that may handicap their functioning capability or their ability to fully care for themselves. The frail elderly, usually thought of as being "at risk" are also usually considered to be the 85+ segment of the population. This is the fastest growing group in the country and, as a point of interest, Pasco and Pinellas Counties currently have the highest percentage concentration of this group in the state.

From the Governor's Consensus Estimating Conference we learn that in 1990 in Florida the 60+ population accounts for 35.5% of the population, the 75+ population for 12.8% and the 85+ population for 3%. The United States Statistical Abstract for 1989 states that Florida ranks number one in the number of persons over the age of 65.

And so it is natural that we would have a special concern for this problem. Today Florida's population distribution is what the rest of the country will be in about 35 years (University of South Florida's

Mental Health Services Training Manual).

The "old old" represented less than one percent of the population in the 1980 census and is expected to increase to more than 5% by 2050, increasing in number from 2.5 million to 16.1 million.

Let us compare the service needs of the various strata of elderly: at 60 about 5% need supportive services; at 75 it is estimated that 10 - 15% need services, and at 85 about 50% need services with some 40% needing assistance on a daily basis (National Institute on Aging).

Clearly the responsibility for the care of the 85+ population rests with both the families involved and the government. As more people live longer, their caregivers (siblings, sons, daughters, or nieces and nephews) will be older. And we have persons in their sixties and seventies who may have health and financial problems of their own, providing care to older parents.

Traditionally, women have been primary caregivers of older relatives. Four social trends, however, are having an effect on this role. First, the increasing divorce rate is creating fragmented and redefined families. Second, the changing characteristics of the older population are requiring caregivers to possess new coping skills. Third, the current geographic mobility of our population is creating the need for "long-distance caregiving" networks. Fourth, and probably most importantly, the spiraling numbers of women in the working world are

forcing a redefinition of the caregiver role. Such a redefinition addresses both the family and the workplace as new sources of support and information in caring for older relatives (Caregiver Support Committee, Federal Council on Aging).

One of the areas which we feel requires special attention in the area of care and support for the "at risk" elderly is in the field of mental health. In Florida the focus has been on the 15% of the population which suffers chronic mental impairment. An estimated 60% of the elderly experience some form of mental illness and frequently are at risk of further difficulty due to trauma, lack of support or undue stress. There is an increasing feeling that depression plays a very important part in the general mental health of the older individual. Our own agency is beginning a pilot program to attempt to address the problem of depression.

It is time to begin to plan for the reauthorization of the Older Americans Act in 1991. The addition, in the past reauthorization, of Title III-D was an important forward step. Our funded projects are taking great care to do effective outreach and are developing innovative ways to target minority and Below Poverty Level clients. They are receiving detailed monitoring to insure this. Those of us who work in the field of aging are grateful for this strengthening. But it is not enough. We definitely do not propose to take away from any needy group now being served, but we do, very strongly, recommend a focus on the 85+ population as a special needs group within the

services provided under Title III B, C, and D. Insufficient attention has been paid to the results of the combination of losses suffered by the 85+ population. They are expected to adjust to the hardest changes in their lives at a time when their resources are at their lowest point. People in later life not only have the highest suicide rate and prevalence of mental disorders, but also consume more drugs and exhibit more alcohol abuse than any other group in the country (Klerman, 1980).

We strongly urge the passage of the bill sponsored by Congressman Bilirakis, HR 1879.

In consideration of the reauthorization of the Older Americans Act it is inevitable that the question of means testing will come up for discussion. We are unalterably opposed to means testing on the grounds that such a procedure would be contrary to the very spirit of the Older Americans Act. Daily, in our office, we hear tales of older individuals or couples, in very real need of services, who refuse help because they don't want to accept what they consider to be "welfare". We believe that means testing, taken to its logical conclusion, would eventually establish a system in which the proud, truly needy, would go without and those with fewer scruples would find a way around the system.

If we wish to consider ourselves a truly good nation, we must make more provisions to care for this 85+ vulnerable segment of our population which has contributed so much to its development.

Thank you for the opportunity to address you.

Mr. DOWNEY. Thank you, Ms. Gronda. Mr. Buchholtz?

STATEMENT OF FREDERIC BUCHHOLTZ

Mr. BUCHHOLTZ. Chairman Downey, Congressman Bilirakis, Congressman Young, you have been welcomed to the area. I would like to welcome you to the Aging Capital of the United States, which is Pinellas County and District 5 of HRS. My name is Fred Buchholtz, and I am the Executive Director of Neighborly Senior Services, which is a private, nonprofit organization that operates in Pinellas County, Florida. We serve 6,000 clients per day, about 15,000 clients per year, and most of those individuals are what we call the old old. About 75 percent of our clients are over the age of 75, and about 39 percent of those are over the age of 85. We provide 13 separate programs with 25 separate services.

In my verbal testimony this morning, I would like to talk about the need for targeting the Older Americans Act funds. In my written testimony, I have addressed several different issues. I would title my testimony, "The Oldest Old—The Need for Targeting of Limited Resources".

One of the major challenges facing our society is how to keep our older population as healthy and independent as possible for as long as possible as we approach the 21st century. This is not only an altruistic objective, but with the U.S. having the largest 80 plus population in the world, an economic imperative as well. A healthy independent older population will be an asset to society, while an older population with many of its members forced into premature or unnecessary institutional settings will pose an untenable economic burden. This challenge becomes more and more difficult every year as our aging population itself continues to age. Yet it is a challenge that we must rise to, or face the tragic and costly consequences.

The elderly population itself is growing older. In fact, the 85 plus is the fastest growing segment of our population, which you have heard many times today already. It is estimated that the 85 plus population will more than double between the year 1980 and the year 2000 and more than double again between the year 2000 and 2040. In fact, the 85 plus population, which I will refer to as the old old, or oldest old, is expected to be seven times as large by the middle of the next century as it was in 1980.

Our country's health care system is based on an acute care model, which I think is part of the problem of the entire system to begin with. The acute care model is characterized by definite onset, crisis, recovery and/or death. However, 54 percent of our 85 plus population have chronic health problems characterized by slow development, multiple body function involvement and irreversibility. There is no quick fix for those kinds of problems. These chronic health problems restrict activities of daily living including shopping, walking, bathing, managing money, performing household chores, toileting, eating and dressing. The elderly with chronic health problems, therefore, frequently need the help of another person in order to manage their daily lives. It is estimated that 40 percent or more, as Sally mentioned, of the 85 plus population will need some type of supportive services at some point in time in

order to maintain their independence. This type of community based help can be provided at comparatively low cost. This has already been said. And can allow the chronically ill elderly to remain in their own homes. Even patients with Alzheimer's disease can spend 80 to 90 percent of their time at home if adequate support is available to caregivers. Without the availability of this community based care, costly, premature and inappropriate institutionalization will result for many.

Given limited Older Americans Act resources, the large number of healthy older persons between the age of 60 and 74 and the large and rapidly growing number of frail and chronically ill persons over the age of 85 in this country, it is abundantly clear that a significant portion of Older Americans Act resources must be targeted to the oldest old; those elderly most likely to require assistance in order to preserve their independence and dignity.

In considering the targeting of Older Americans Act resources for those in greatest social and economic need, little mention has been given to the fact that 72 percent of those over the age of 85 are women, whose incidence of poverty is significantly higher than that of their male counterparts, and that this incidence increases with advanced age. In fact, 40 percent of women over the age of 85 are near or below the poverty level. They are also more likely to be widowed. As a result of these factors, they are more likely to lack sufficient family support, be transportation disadvantaged and have physical and mental impairments which threaten their independence and quality of life. Surely this cohort qualifies as being in greatest social and economic need. And I would urge the committee in taking a look at that definition to consider those factors.

The Older Americans Act does not target resources to the oldest old. A weighted 85 plus factor should be included in the Older Americans Act interstate funding formula, and required in intrastate funding formulas. To date, the only real targeting of OAA resources to the oldest old has been at the provider agency level. But targeting funding at this level is like closing the barn door after the horse is out. It does not provide adequate resources to those geographic areas with the largest old old populations. In order for targeting to provide sufficient funding to be of real benefit to this cohort, the targeting must also be done by providing States which have high concentrations of the oldest old with more funds and requiring them to allocate those funds proportionately to the size of the old old population within their planning and service areas. This would ensure that limited resources are placed where they can do the most good, and have the greatest impact on preserving independence and dignity for our older population. We commend Congressman Bilirakis for introducing H.R. 1879 which we think goes very far in this process of targeting these Older Americans Act resources. He has obtained a number of sponsors already, and we appreciate the sponsorships that he has obtained. We certainly would like to see more Congressmen cosponsor the bill, and we certainly would like to see a companion bill in the Senate as well.

It is ironic that at a time when the significant and compelling needs of the oldest old are coming to the fore, a shortsighted ruling by a Federal district court in the Southern District of Florida has decimated the funding of two areas of the State with the largest

old old populations. Not only the largest old old populations in the State, but in the entire country. As a result of the decision in the case of "Meek versus Martinez", the State was mandated to adopt and perpetuate a new formula for distributing Older Americans Act funds to its 11 planning and service areas, known as districts.

As a result of this new formula, District 5, which includes Pinellas County, which you are in, and Pasco County to the north, with the largest number of 60 plus and 85 plus in the State, and District 10, which is Broward County, with the third largest 85 plus population in the State, will suffer staggering losses of critically needed Older Americans Act funds. Beginning in 1991, District 5, our district, will lose $1,270,000 each year and District 10 will lose $825,000 each year. Our district has 421,000 individuals over the age of 60, and 30,863 individuals over the age of 85. Our 85 plus population in Pinellas County constitutes over 16 percent of the entire State's 85 plus population. And a statistic Margaret Lynn Duggar brought to my attention, which I thought was very interesting, Pinellas County has more older people than 16 other States—just our county. So you can see the scope of this. The magnitude is quite staggering.

Without intervention, the impact of this recurring loss will be devastating. It will result in termination of essential services such as adult day care, meals on wheels, transportation, congregate dining, mental health counseling, chore services, homemaking, guardianship and others to approximately 10,000 clients in our district alone. These clients depend on these services to maintain their independence. More costly institutionalization and avoidable loss of life will result. When one further considers that fact that our district already has thousands of elderly on the waiting list—in fact, our agency had 1,800 people on the waiting list at the early part of the year and currently has 1,500 people on our waiting list—and that is just our agency, and further cuts coupled with cost increases due to inflation, this will result in further service reductions. It is clear that something must be done to avoid an impending crisis.

I am summarizing my remarks at this point. Florida having the greatest percentage of its population over the age of 85 in the Nation is a social laboratory in which the problems that will confront other States in the future exists today. Let us learn from the experiences of our State with regard to the need for targeting of limited resources and demonstrate together how to facilitate maximum independence for the oldest old by the prudent use of those funds.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Buchholtz follows:]

STATEMENT OF FREDRIC BUCHHOLTZ
EXECUTIVE DIRECTOR, NEIGHBORLY SENIOR SERVICES, INC.
PINELLAS COUNTY, FLORIDA
PREPARED FOR THE PUBLIC HEARING OF THE
HOUSE SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HUMAN SERVICES
CLEARWATER CITY HALL ANNEX, COMMUNITY HALL
10 MISSOURI AVENUE SOUTH
CLEARWATER, FLORIDA
MARCH 5, 1990

MY NAME IS FRED BUCHHOLTZ AND I AM THE EXECUTIVE DIRECTOR OF NEIGHBORLY SENIOR SERVICES, INC., (NSS) A PRIVATE NOT-FOR-PROFIT AGENCY WHICH SERVES OVER 6,000 ELDERLY PERSONS PER DAY THROUGHOUT PINELLAS COUNTY, FLORIDA.

I WISH TO THANK CHAIRMAN DOWNEY AND CONGRESSMAN BILIRAKIS FOR THIS OPPORTUNITY TO PRESENT MY VIEWS ON MEETING THE NEEDS OF THE FRAIL ELDERLY TO THE SELECT COMMITTEE ON AGING, SUBCOMMITTEE ON HUMAN SERVICES, IN ANTICIPATION OF THE 1991 REAUTHORIZATION OF THE OLDER AMERICANS ACT.

OVERVIEW OF NEIGHBORLY SENIOR SERVICES

NEIGHBORLY SENIOR SERVICES, INC. SERVES APPROXIMATELY 6,000 OLDER PERSONS PER DAY, 15,000 PER YEAR, IN 13 SEPARATE PROGRAMS WHICH PROVIDE MORE THAN 25 DISTINCT SERVICES.

OUR SERVICES INCLUDE:

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- ADULT DAY HEALTH CARE
- CONGREGATE DINING
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- TRANSPORTATION
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  - ADULT DAY CARE
  - ADULT DAY HEALTH CARE
  - CHORE SERVICE
  - HOME DELIVERED MEALS
  - EMERGENCY ALERT/RESPONSE
  - HOME HEALTH AIDE
  - HOMEMAKER
  - HOME NURSING
  - MEDICAL TRANSPORTATION
  - OCCUPATIONAL THERAPY
  - PHYSICAL THERAPY
  - SPEECH THERAPY
  - PERSONAL CARE
  - RESPITE CARE
- NURSING HOME DIVERSION

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THERAPEUTIC MEALS FOR THOSE ON PHYSICIAN PRESCRIBED DIETS
SUPPORT GROUPS FOR FAMILY CAREGIVERS
TELEPHONE REASSURANCE CALLS AND VOLUNTEER VISITS

NSS TAKES A "HOLISTIC" APPROACH TO MEETING THE NEEDS OF THE OLDER PERSON IN NEED OF SUPPORTIVE SERVICES, I.E., WE LOOK AT THE MULTIPLE AND INSEPARABLE NEEDS OF THE INDIVIDUAL, AND ATTEMPT TO MATCH THEIR NEEDS WITH ALL RESOURCES AVAILABLE IN THE COMMUNITY, INCLUDING, BUT NOT LIMITED TO, THOSE UNDER OUR CONTROL, THOSE AVAILABLE THROUGHOUT THE "AGING NETWORK", AND THEIR OWN.

THE SERVICES OF NSS ARE DESIGNED TO FACILITATE MAXIMUM INDEPENDENCE AND PREVENT OR DELAY PREMATURE AND INAPPROPRIATE INSTITUTIONALIZATION OF THE ELDERLY. SERVICES EMPHASIZE QUALITY, CHOICE AND ACCESS AS WELL AS CLIENT, FAMILY CAREGIVER AND COMMUNITY INVOLVEMENT.

WHILE SERVICES ARE AVAILABLE TO THOSE WHO ARE OVER THE AGE OF 60, NSS SERVES PRIMARILY THE OLD OLD. NEARLY THREE QUARTERS OF OUR CLIENTS ARE OVER THE AGE OF 75, AND 39% OF THOSE ARE OVER THE AGE OF 85.

OUR ANNUAL OPERATING BUDGET FOR 1990 IS $10.7 MILLION AND IS DERIVED FROM 33 FUNDING SOURCES INCLUDING STATE AND FEDERAL GOVERNMENT, LOCAL MUNICIPALITIES, THE UNITED WAY AND LOCAL FUNDRAISING.

NSS HAS 232 FULL AND PART TIME EMPLOYEES, AND AN ADDITIONAL 46 SENIOR COMMUNITY AIDES, FUNDED UNDER THE SENIOR COMMUNITY SERVICES EMPLOYMENT PROGRAM, WITHOUT WHOM, WE WOULD HAVE SIGNIFICANT DIFFICULTY PROVIDING OUR SERVICES.

NSS' WAITING LIST NUMBERED 1,800 PERSONS WITHIN THE PAST SEVERAL MONTHS, AND CURRENTLY NUMBERS OVER 1,500.

OVERVIEW

IN MY TESTIMONY TODAY, I WILL ADDRESS:

1. THE NEED FOR TARGETING OF OLDER AMERICANS ACT RESOURCES;
2. THE NEED FOR ADEQUATELY FUNDING PROGRAMS CURRENTLY IN EXISTENCE;

3. THE NEED FOR PROVIDING A BROADER ARRAY OF SERVICES TO MEET THE NEEDS OF THE OLDEST OLD;
4. THE NEED TO STRENGTHEN PROVIDER AGENCIES.

THE OLDEST OLD: THE NEED FOR TARGETING OF LIMITED RESOURCES

ONE OF THE MAJOR CHALLENGES FACING OUR SOCIETY IS HOW TO KEEP OUR OLDER POPULATION AS HEALTHY AND INDEPENDENT AS POSSIBLE AS WE APPROACH THE 21ST CENTURY. THIS IS NOT ONLY AN ALTRUISTIC OBJECTIVE, BUT, WITH THE U.S. HAVING THE LARGEST 80+ POPULATION IN THE WORLD, AN ECONOMIC IMPERATIVE AS WELL. A HEALTHY INDEPENDENT OLDER POPULATION WILL BE AN ASSET TO SOCIETY, WHILE AN OLDER POPULATION WITH MANY OF ITS MEMBERS FORCED INTO PREMATURE OR UNNECESSARY INSTITUTIONAL SETTINGS WILL POSE AN UNTENABLE ECONOMIC BURDEN. THIS CHALLENGE BECOMES MORE AND MORE DIFFICULT EVERY YEAR AS OUR AGING POPULATION ITSELF CONTINUES TO AGE, YET IT IS A CHALLENGE THAT WE MUST RISE TO, OR FACE TRAGIC AND COSTLY CONSEQUENCES.

THE ELDERLY POPULATION ITSELF IS GROWING OLDER, IN FACT, THE 85+ IS THE FASTEST GROWING SEGMENT OF OUR POPULATION. IT IS ESTIMATED THAT THE 85+ POPULATION WILL MORE THAN DOUBLE BETWEEN THE YEAR 1980 AND THE YEAR 2000 (INCREASING FROM 2.39 MILLION PERSONS TO 5.16 MILLION PERSONS, A 116% INCREASE), AND MORE THAN DOUBLE AGAIN BETWEEN THE YEAR 2000 AND THE YEAR 2040, (AN ADDITIONAL INCREASE OF 153%). IN FACT THE 85+ POPULATION, WHICH I WILL REFER TO AS THE OLD OLD, OR OLDEST OLD, IS EXPECTED TO BE SEVEN TIMES AS LARGE BY THE MIDDLE OF THE NEXT CENTURY AS IT WAS IN 1980.

OUR COUNTRY'S HEALTH CARE SYSTEM IS BASED ON AN ACUTE CARE MEDICAL MODEL, CHARACTERIZED BY DEFINITE ONSET, CRISIS, RECOVERY AND/OR DEATH. HOWEVER 54% OF OUR 85+ POPULATION HAVE CHRONIC HEALTH PROBLEMS, CHARACTERIZED BY SLOW DEVELOPMENT, MULTIPLE BODY FUNCTION INVOLVEMENT AND IRREVERSIBITY. THESE CHRONIC HEALTH PROBLEMS RESTRICT ACTIVITIES OF DAILY LIVING INCLUDING SHOPPING, WALKING, BATHING, MANAGING MONEY, PERFORMING HOUSEHOLD CHORES, TOILETING, EATING AND DRESSING. THE ELDERLY WITH CHRONIC HEALTH PROBLEMS, THEREFORE, FREQUENTLY NEED THE HELP OF ANOTHER PERSON IN ORDER TO MANAGE THEIR DAILY LIVES. IT IS ESTIMATED THAT 40% OR MORE OF THE 85+ POPULATION WILL NEED SOME TYPE OF SUPPORTIVE SERVICE AT SOME POINT IN TIME, IN ORDER TO MAINTAIN THEIR INDEPENDENCE. THIS TYPE OF COMMUNITY BASED HELP CAN BE PROVIDED AT COMPARATIVELY LOW COST, AND CAN ALLOW THE CHRONICALLY ILL ELDERLY TO REMAIN IN THEIR OWN HOMES. EVEN PATIENTS WITH ALZHEIMER'S DISEASE CAN SPEND 80-90% OF THEIR TIME AT HOME IF ADEQUATE SUPPORT IS AVAILABLE TO CAREGIVERS. WITHOUT THE AVAILABILITY OF THIS COMMUNITY BASED CARE, COSTLY, PREMATURE AND INAPPROPRIATE INSTITUTIONALIZATION WILL RESULT FOR MANY.

GIVEN LIMITED OLDER AMERICANS ACT RESOURCES, THE LARGE NUMBER OF HEALTHY OLDER PERSONS BETWEEN THE AGES OF 60-74, AND THE LARGE AND RAPIDLY GROWING NUMBER OF FRAIL AND CHRONICALLY ILL PERSONS OVER THE AGE OF 85 IN THIS COUNTRY, IT IS ABUNDANTLY CLEAR THAT A SIGNIFICANT PORTION OF OLDER AMERICANS ACT RESOURCES MUST BE TARGETED TO THE OLDEST OLD; THOSE ELDERLY MOST LIKELY TO REQUIRE ASSISTANCE IN ORDER TO PRESERVE THEIR INDEPENDENCE AND DIGNITY. I AM NOT SUGGESTING THAT THIS TARGETING BE DONE TO THE TOTAL EXCLUSION OF THE YOUNGER

OLD WHO ALSO HAVE NEEDS, MANY OF WHICH SHOULD BE ADDRESSED ON A PREVENTATIVE BASIS, BUT THAT WE MUST EMPHASIZE FUNDING TO MEET THE MOST SIGNIFICANT NEEDS.

IN CONSIDERING THE TARGETING OF OAA RESOURCES FOR THOSE IN GREATEST SOCIAL AND ECONOMIC NEED, LITTLE MENTION HAS BEEN MADE OF THE FACT THAT 72% OF THOSE OVER THE AGE OF 85 ARE WOMEN WHOSE INCIDENCE OF POVERTY IS SIGNIFICANTLY HIGHER THAN THAT OF THEIR MALE COUNTERPARTS, AND THAT THIS INCIDENCE INCREASES WITH ADVANCED AGE. IN FACT, 40% OF WOMEN OVER THE AGE OF 85 ARE NEAR OR BELOW THE POVERTY LEVEL. THEY ARE ALSO MORE LIKELY TO BE WIDOWED. AS A RESULT OF THESE FACTORS THEY ARE MORE LIKELY TO LACK SUFFICIENT FAMILY SUPPORT, BE TRANSPORTATION DISADVANTAGED, AND HAVE PHYSICAL AND MENTAL IMPAIRMENTS WHICH THREATEN THEIR INDEPENDENCE AND QUALITY OF LIFE. SURELY THIS COHORT QUALIFIES AS BEING IN GREATEST SOCIAL AND ECONOMIC NEED.

THE OLDER AMERICANS ACT DOES NOT TARGET RESOURCES TO THE OLDEST OLD. A WEIGHTED 85+ FACTOR SHOULD BE INCLUDED IN THE OAA INTERSTATE FUNDING FORMULA, AND REQUIRED IN INTRASTATE FUNDING FORMULAS. TO DATE, THE ONLY REAL TARGETING OF OAA RESOURCES TO THE OLDEST OLD HAS BEEN AT THE PROVIDER AGENCY LEVEL. AS MENTIONED PREVIOUSLY, 75% OF NSS' CLIENTS ARE OVER THE AGE OF 75, AND 39% OF THOSE ARE OVER THE AGE OF 85. BUT TARGETING FUNDING AT THIS LEVEL IS LIKE CLOSING THE BARN DOOR AFTER THE HORSE IS OUT--IT DOES NOT PROVIDE ADEQUATE RESOURCES TO THOSE GEOGRAPHIC AREAS WITH THE LARGEST OLD OLD POPULATIONS. IN ORDER FOR TARGETING TO PROVIDE SUFFICIENT FUNDING TO BE OF REAL BENEFIT TO THIS COHORT, THE TARGETING MUST ALSO BE DONE BY PROVIDING STATES WHICH HAVE HIGH CONCENTRATIONS OF THE OLDEST OLD, WITH MORE FUNDS, AND REQUIRING THEM TO ALLOCATE THOSE FUNDS PROPORTIONATELY TO THE SIZE OF THE OLD OLD POPULATION WITHIN THEIR PLANNING AND SERVICE AREAS. THIS WOULD ENSURE THAT LIMITED RESOURCES ARE PLACED WHERE THEY CAN DO THE MOST GOOD, AND HAVE THE GREATEST IMPACT ON PRESERVING INDEPENDENCE AND DIGNITY FOR OUR OLDER POPULATION. WE COMMEND CONGRESSMAN MICHAEL BILIRAKIS FOR INTRODUCING H.R. 1879 WHICH PROVIDES A GOOD BEGINNING FOR THIS TARGETING PROCESS. THIS BILL HAS A NUMBER OF SPONSORS IN THE HOUSE OF REPRESENTATIVES, BUT AS YET, THERE IS NO COMPANION BILL IN THE SENATE.

IT IS IRONIC THAT AT A TIME WHEN THE SIGNIFICANT AND COMPELLING NEEDS OF THE OLDEST OLD ARE COMING TO THE FORE, A SHORTSIGHTED RULING BY A FEDERAL DISTRICT COURT IN THE SOUTHERN DISTRICT OF FLORIDA HAS DECIMATED THE FUNDING OF TWO AREAS OF THE STATE WITH THE LARGEST OLD OLD POPULATIONS IN THE STATE, AND IN THE COUNTRY.

THERE ARE 11 PLANNING AND SERVICE AREAS IN THE STATE OF FLORIDA, KNOWN AS DISTRICTS. THE ELDERLY OF DISTRICT 5 (PINELLAS AND PASCO COUNTIES) AND OF DISTRICT 10 (BROWARD COUNTY) HAVE BEEN PLACED AT IMMINENT RISK OF LOSING EXISTING SERVICES IN THE AFTERMATH OF THE FEDERAL DISTRICT COURT'S RULING IN THE CASE OF MEEK VS. MARTINEZ, ET AL. THE STATE WAS MANDATED TO ADOPT AND PERPETUATE A NEW FORMULA (REFERRED TO AS AN "INTRASTATE FUNDING FORMULA") FOR DISTRIBUTING OLDER AMERICANS ACT FUNDS TO ITS ELEVEN PLANNING AND SERVICE AREAS.

AS A RESULT OF THIS NEW FORMULA, DISTRICT 5, WITH THE LARGEST NUMBER OF 60+ AND 85+ IN THE STATE, AND DISTRICT 10 WITH THE THIRD LARGEST 85+ POPULATION IN THE STATE WILL SUFFER STAGGERING LOSSES OF CRITICALLY NEEDED OLDER AMERICANS ACT FUNDS. BEGINNING IN 1991, DISTRICT 5 WILL LOSE $1,270,000 EACH YEAR, AND DISTRICT 10 WILL LOSE $825,000 EACH YEAR.

DISTRICT 5 HAS 421,112 INDIVIDUALS OVER THE AGE OF 60 AND 30,863 INDIVIDUALS OVER THE AGE OF 85. OUR 85+ POPULATION CONSTITUTES OVER 16% OF THE ENTIRE STATE'S 85+ POPULATION. PINELLAS COUNTY ALONE HAS MORE ELDERLY THAN 16 STATES.

WITHOUT INTERVENTION ON THE PART OF THE STATE LEGISLATURE DURING THE UPCOMING SESSION, THE IMPACT OF THIS RECURRING LOSS WILL BE DEVASTATING. IT WILL RESULT IN TERMINATION OF ESSENTIAL SERVICES SUCH AS ADULT DAY CARE, MEALS ON WHEELS, TRANSPORTATION, CONGREGATE DINING, MENTAL HEALTH COUNSELING, CHORE SERVICES, HOMEMAKER, GUARDIANSHIP AND OTHERS TO APPROXIMATELY 10,000 ELDERLY CLIENTS IN DISTRICT 5 ALONE, WHO DEPEND ON THESE SERVICES TO HELP MAINTAIN THEIR INDEPENDENCE. MORE COSTLY INSTITUTIONALIZATION AND AVOIDABLE LOSS OF LIFE WILL RESULT. WHEN ONE FURTHER CONSIDERS THE FACT THAT OUR DISTRICT ALREADY HAS THOUSANDS OF OLDER PERSONS ON WAITING LISTS FOR SERVICES, AND THAT OTHER CUTS, COUPLED WITH COST INCREASES DUE TO INFLATION, WILL RESULT IN FURTHER SERVICE REDUCTIONS, IT IS CLEAR THAT SOMETHING MUST BE DONE TO AVERT AN IMPENDING CRISIS.

FLORIDA, HAVING THE GREATEST PERCENT OF ITS POPULATION OVER THE AGE OF 85 IN THE NATION, IS A SOCIAL LABORATORY IN WHICH THE PROBLEMS THAT WILL CONFRONT OTHER STATES IN THE FUTURE, EXIST TODAY. LET US LEARN FROM THE EXPERIENCES OF OUR STATE WITH REGARD TO THE NEED FOR TARGETING OF LIMITED RESOURCES, AND DEMONSTRATE HOW TO FACILITATE MAXIMUM INDEPENDENCE FOR OUR OLDEST OLD BY THEIR PRUDENT USE.

ADEQUATE FUNDING OF EXISTING PROGRAMS AND EXPANSION OF SERVICE OPTIONS

THE TARGETING OF INSUFFICIENT RESOURCES IS OBVIOUSLY NOT THE TOTAL ANSWER. WE MUST ALSO: (1) ENSURE THE PROVISION OF ADEQUATE FUNDING OF EXISTING PROGRAMS THAT HAVE DEMONSTRATED THEIR EFFECTIVENESS, AND (2) EXPAND THE SERVICES PROVIDED UNDER THE OLDER AMERICANS ACT TO INCLUDE THOSE MOST NEEDED BY THE OLDEST OLD.

THE OLDER AMERICANS ACT SHOULD BE EXPANDED TO INCLUDE A MUCH BROADER ARRAY OF SERVICES NEEDED BY AN INCREASINGLY OLD AND CHRONICALLY IMPAIRED POPULATION, IN ORDER TO MAINTAIN THEIR INDEPENDENCE. THE CONTINUUM OF SERVICES PROVIDED WITHIN THE STATE OF FLORIDA SHOULD BE LOOKED AT AS ONE POSSIBLE MODEL. HOWEVER, WHILE FLORIDA HAS A WIDE ARRAY OF SERVICES, THEY TEND TO BE POORLY FUNDED, OVERWHELMED BY THE NEEDS OF OUR OLD OLD POPULATION, AND THOUSANDS OF CLIENTS ARE ON WAITING LISTS STATEWIDE. AN 85+ YEAR-OLD CLIENT IN NSS' STATE FUNDED CCE PROGRAM, FOR EXAMPLE, IS LIKELY TO RECEIVE ONLY 3 HOURS OF HOMEMAKER SERVICE PER WEEK, WHICH IS LESS THAN HALF THE NUMBER OF HOURS NEEDED. HOW CAN AN 85+ YEAR-OLD FRAIL CLIENT BE EFFECTIVELY KEPT OUT OF A NURSING HOME WITH 3 HOURS OF HOMEMAKER SERVICE PER WEEK? THE CCE PROGRAM, STATEWIDE, HAS A WAITING LIST OF NEARLY 10,000 PERSONS. THE STATE FUNDED ALZHEIMER'S DISEASE INITIATIVE PROGRAM (RESPITE CARE) IS ANOTHER EXAMPLE OF THE INADEQUACY OF STATE FUNDING. NSS' ADI PROGRAM CURRENTLY SERVES 85 PERSONS AND HAS A WAITING LIST OF 96 PERSONS. FAMILIES WHICH DO RECEIVE SERVICES NEED A MINIMUM OF 12 HOURS OF RESPITE CARE PER WEEK, BUT CURRENTLY RECEIVE ONLY 6 OR 7. OTHER EXAMPLES ABOUND. NEIGHBORLY SENIOR SERVICES ALONE CURRENTLY HAS OVER 1,500 ELDERLY PERSONS ON WAITING LISTS IN VARIOUS PROGRAMS. LONG WAITING LISTS ARE NOT

UNCOMMON TO PROGRAMS IN AREAS WHERE THERE IS A HIGH INCIDENCE OF THE OLDEST OLD.

THOUSANDS OF OLDER PERSONS IN FLORIDA WHO ARE IN NEED OF SERVICES WHICH COULD HELP TO MAINTAIN THEIR INDEPENDENCE WILL RUN OUT OF TIME BEFORE SERVICES CAN BE PROVIDED.

FOR THOSE WHO ARE FORTUNATE ENOUGH TO RECEIVE OAA SERVICES, THE LEVEL OF SERVICE PROVIDED IS ALSO FREQUENTLY INADEQUATE. QUOTAS ARE OFTEN SHARED BY MORE THAN ONE CLIENT, RESULTING IN THE PROVISION OF A FRACTION OF THE LEVEL OF SERVICE NEEDED.

IN THE HUMAN SERVICE SECTOR IN GENERAL, CONTINUED AND INCREASING INSUFFICIENCY OF FUNDING HAS FORCED HUMAN SERVICE ORGANIZATIONS SERVING URGENT LEGITIMATE NEEDS TO COMPETE WITH AGENCIES MEETING OTHER LEGITIMATE NEEDS FOR A GREATER SHARE OF AN INADEQUATE AND SHRINKING PIE. THIS TOTALLY COUNTER-PRODUCTIVE ACTIVITY RESULTS IN THE EXPENDITURE OF FUTILE EFFORT - EFFORT WHICH COULD BE BETTER EXPENDED ON MEETING HUMAN SERVICE NEEDS. ALL THE WHILE, NEEDS, AS WELL AS COSTS, CONTINUE TO ESCALATE.

FOR THE PAST SEVERAL YEARS, FUNDING UNDER THE OLDER AMERICANS ACT HAS REMAINED VIRTUALLY FLAT, WHICH HAS RESULTED IN THE EROSION OF THOUSANDS OF UNITS OF SERVICE DUE TO INFLATION (INCLUDING SIGNIFICANT INCREASES IN FOOD AND LABOR COSTS, WORKERS COMPENSATION, GROUP HEALTH INSURANCE, LIABILITY INSURANCE AND OTHERS). THIS EROSION, WHICH HAS TAKEN PLACE CONCURRENTLY ALONG WITH A DRAMATIC INCREASE IN THE NUMBERS OF THE OLDEST OLD (WHO ARE IN GREATEST NEED OF THE GREATEST AMOUNT OF SERVICE), WILL FORCE EVEN MORE FAMILIES TO INSTITUTIONALIZE THEIR LOVED ONES PREMATURELY, AND IRONICALLY, AT A MUCH HIGHER COST TO BOTH STATE AND FEDERAL TAXPAYERS. THE CONGRESS SHOULD ALLOCATE SIGNIFICANT INCREASES UNDER THE OLDER AMERICANS ACT TO KEEP PACE WITH BOTH THE GROWTH OF THE OLDER POPULATION AND THE CHANGING NATURE OF THEIR NEEDS.

THERE IS A CERTAIN FUTILITY IN ANY EFFORT WHICH WOULD ATTEMPT TO DEAL WITH THE SIGNIFICANT UNMET NEEDS OF OUR OLDER POPULATION WITHOUT ALSO ADDRESSING THE SIGNIFICANT RESOURCES WHICH MUST BE PROVIDED TO MEET THOSE NEEDS. ONE NEED ONLY CONSIDER THE ANALOGY OF TRYING TO TUNE A CAR ENGINE WHEN THERE IS NO GASOLINE IN THE TANK. WE MUST NOT DEVOTE TOO MUCH OF OUR ENERGIES TO REHASHING THE SAME SHORTSIGHTED QUESTION: 'HOW CAN WE MEET THE GROWING NEEDS OF OUR INCREASINGLY OLDER POPULATION WITH A SHRINKING PIE OF FINANCIAL RESOURCES?' THE HUMAN SERVICE NEEDS OF OUR ELDERLY POPULATION ARE INCREASING EXPONENTIALLY. THESE NEEDS CANNOT BE MET SIMPLY BY REHASHING STRATEGIES AND REDIVIDING THE SAME INADEQUATE PIE. IN FACT, TO SOME EXTENT, THIS KIND OF ACTIVITY DIVERTS OUR ATTENTION FROM PERHAPS THE MOST CRITICAL NEED AREA, WHICH IS ADEQUATE RESOURCES. THE NEEDS OF THE OLDEST OLD WILL ONLY BE MET WHEN WE HAVE STRONG LEADERSHIP (IN BOTH THE PUBLIC AND PRIVATE SECTORS), WHICH HAS AN UNDERSTANDING THAT IT IS NOT ONLY MORE HUMANE, BUT MORE ECONOMICAL IN THE LONG RUN, TO PROVIDE ADEQUATE RESOURCES TO ASSIST OLDER PEOPLE TO LIVE IN THEIR OWN HOMES, INDEPENDENTLY, THAN IT IS TO SPEND MANY TIMES THAT AMOUNT TO PROVIDE THE CARE OF LAST RESORT, INSTITUTIONAL CARE. THAT THIS LEADERSHIP WILL HAVE TO DEMONSTRATE THE COURAGE OF ITS CONVICTIONS, PERHAPS AT GREAT POLITICAL RISK, GOES WITHOUT SAYING.

THE REAL ISSUE IS NOT HOW TO RE-DIVIDE WHAT'S LEFT OF MEAGER FUNDING AFTER THE RAVAGES OF INFLATION, MINIMUM WAGE, WORKER'S COMPENSATION, GROUP HEALTH PREMIUM

INCREASES, GRAMM-RUDMAN-HOLLINGS, STATE GENERAL REVENUE SHORTFALLS, MEEK VS. MARTINEZ, AND A MYRIAD OF OTHER EROSIONS, BUT HOW WE WILL INCREASE NEEDED REVENUES SO THAT THE PRESSING AND LEGITIMATE HUMAN SERVICE NEEDS OF OUR FRAIL ELDERLY POPULATION CAN BE MET ON A REASONABLE AND RESPECTABLE LEVEL.

IT IS MY HOPE THAT THIS OVERSIGHT COMMITTEE WILL MAKE PROVIDING THE VISION AND LEADERSHIP NECESSARY TO ACCOMPLISH THIS TASK, ONE OF ITS MAIN CONCERNS IN THIS AND COMING YEARS. TO DO ANY LESS WOULD BE TO CIRCUMVENT THE PROBLEM, RATHER THAN TO ADDRESS IT.

STRENGTHENING OF PROVIDER AGENCIES AND LOCUS OF CASE MANAGEMENT

SOCIAL ARCHITECTS AT BOTH THE STATE AND FEDERAL LEVELS OF GOVERNMENT ARE CONSIDERING HOW BEST TO REORGANIZE THE AGING NETWORK FOR MAXIMUM EFFICIENCY AND EFFECTIVENESS. ONE ISSUE BEING CONSIDERED IS THE MOST APPROPRIATE LOCUS FOR CASE MANAGEMENT. ONE OF THE GREAT STRENGTHS OF OF THE AGING NETWORK, A NETWORK OF NOT-FOR-PROFIT SERVICE PROVIDERS AND FUNDING ENTITIES DEDICATED TO THE PROVISION OF A DECENT QUALITY OF LIFE FOR ALL OLDER PERSONS IN OUR SOCIETY, IS MOTIVE. THE MOTIVE OF THE NOT-FOR-PROFIT SECTOR IS ALTRUISTIC, SOCIAL AND ETHICAL IN NATURE. NEIGHBORLY SENIOR SERVICES, LIKE THOUSANDS OF OTHER NOT-FOR-PROFIT AGENCIES, WAS CREATED OUT OF A COMMUNITY'S GRASS ROOTS SOCIAL CONCERN FOR THE WELL-BEING OF ITS OLDER CITIZENS. THESE NOT-FOR-PROFIT ENTITIES ONLY EXIST BECAUSE OF THEIR INTEREST IN THE CLIENT AS AN INDIVIDUAL AND IN THE ABATEMENT OF NEGATIVE SOCIAL CONDITIONS. AS SOCIAL ARCHITECTS CONSIDER HOW BEST TO ORGANIZE THE AGING NETWORK, EXTREME CARE SHOULD BE TAKEN TO PROTECT NOT-FOR-PROFIT IDEALS AND MOTIVES. NOT-FOR-PROFITS SHOULD NOT BE FORCED TO RELINQUISH THEIR ESSENTIAL INTEREST IN CLIENT OUTCOMES IN FAVOR OF COMPETING WITH THE PROPRIETARY SECTOR AS THE LOW BIDDER OF IMPERSONAL UNITS OF SERVICE. TO DO SO COULD SERIOUSLY DAMAGE ONE OF THE GRANDEST AND MOST SUCCESSFUL VOLUNTARY SECTOR EFFORTS OF OUR TIME.

SOME OTHER ISSUES TO CONSIDER:

THE SUICIDE RATE OF THE ELDERLY IS UNACCEPTABLY HIGH

THE ELDERLY ACCOUNT FOR APPROXIMATELY 12% OF OUR NATIONAL POPULATION, BUT 25% OF ALL SUICIDES. FEDERAL RESOURCES SHOULD BE TARGETED TO REDUCING THE RATE OF SUICIDES AMONG OUR ELDERLY POPULATION THROUGH EDUCATIONAL, COUNSELING AND EARLY INTERVENTION PROGRAMS.

SEASONAL MIGRATION IMPACT FUNDING

THE STATE OF FLORIDA SERVES PERSONS WITH OLDER AMERICANS ACT FUNDS WHO ARE LEGALLY RESIDENTS OF OTHER STATES, BUT SPEND 4-6 MONTHS PER YEAR IN FLORIDA FOR

HEALTH OR OTHER REASONS. THE FULL 12 MONTHS OF OAA APPROPRIATION IS ALLOTTED TO THEIR "HOME STATE." THE STATE OF FLORIDA AND OTHER SIMILARLY AFFECTED STATES SHOULD RECEIVE "SEASONAL MIGRATION IMPACT FUNDING" FROM THE OLDER AMERICANS ACT TO COVER THE COST OF MEETING THE NEEDS OF THOSE AMONG THIS GROUP WHO REQUIRE SERVICES UNDER THE OLDER AMERICANS ACT. THIS WOULD BE ANOTHER METHOD OF TARGETING FUNDS TO WHERE THE SERVICES ARE UTILIZED.

SUPPORT OF SCSEP PROGRAM

THE SENIOR COMMUNITY SERVICES EMPLOYMENT PROGRAM (SCSEP) PROVIDES CRITICALLY NEEDED MANPOWER TO THE AGING NETWORK, WHILE AT THE SAME TIME PROVIDING TRAINING AND CAREER OPPORTUNITIES FOR THE ELDERLY. THIS PROGRAM, WHICH IS REGULARLY THREATENED WITH FUNDING REDUCTIONS, SHOULD RECEIVE SUFFICIENT LEVELS OF FUNDING, AS IT PROVIDES MUCH NEEDED BACKBONE TO THE AGING NETWORK. PRESENTLY, DUE TO GRAMM-RUDMAN CUTS, 2,060 CURRENTLY EMPLOYED ELDERLY PERSONS NATIONALLY WILL BE CUT FROM THIS PROGRAM NEXT YEAR. THE INCREASE IN MINIMUM WAGE WILL RESULT IN FURTHER CUTS. THESE FUNDS SHOULD SHOULD BE RESTORED TO THE SCSEP PROGRAM.

THANK YOU CHAIRMAN DOWNEY AND CONGRESSMAN BILIRAKIS FOR THIS OPPORTUNITY TO EXPRESS MY VIEWS. I ALSO WANT TO THANK THE HOUSE SELECT COMMITTEE ON AGING FOR ITS CONTINUING EFFORTS TO ENSURE A BETTER QUALITY OF LIFE FOR THE ELDERLY OF THIS GREAT NATION.

STATEMENT OF BILL AYCRIGG

Mr. AYCRIGG. Congressman Bilirakis, Chairman Downey, Congressman Young, thank you for the opportunity to address these vital issues here today. Greetings, everybody in the audience. I want to make some brief informal remarks before I make my formal presentation. I was very pleased that the panel discussion began this morning in hearing from Mrs. Elizabeth Palmer and Mr. Vincent Cavo because I think they provide personal witnessing of what we need to pay attention to as we look at the reauthorization of the Older Americans Act. What they were expressing was a partnership between their personal private resources as caregivers and family members, and government and public funding. I do not think that there is any question that what they are doing and what they are accomplishing as a result of a nominal investment of dollars is not only of benefit to them and their loved ones but also to our general society as their loved ones remain in their homes.

I happen to be the Assistant Executive Director of Community Aging and Retirement Services which is the lead agency for publicly funded elderly services in Pasco County, just north of us. I am also the immediate past president of the Alzheimer's Disease Support Group in Pasco County, which represents some 250 families who have a member suffering from dementia. I do not know if any of you happened to see the article in the paper this morning, but I think it presents a consequence of what happens when there is inadequate funding in a partnership with families in caregiving. This unfortunate article is about murder/suicide amongst the elderly in our immediate area. Interestingly and unfortunately, the statistic for Pinellas and Pasco County reveal that of the 218 suicides in our two county area in 1989, 99 or 45 percent of the individuals were 60 years and older. It is a matter of life and death in many cases when we are talking about this partnership of public dollars and private family caregiving.

My formal remarks today are entitled, "Meeting the Needs of the Frail Elderly".

Becoming old is no longer just a fact of life but a matter of social revolution with changes everywhere in our society. The aging of society today, and more importantly in the future, will cause dramatic changes for everyone. Demographers are predicting average life expectancies exceeding 100 years or greater by the middle of the 21st century. One school of thought proposes that the elderly will live longer, be healthier and wealthier. Other experts in gerontology portray an elderly population needing expensive and continual medical care with fewer young people to support them. We must address the answers to questions of the aging issue as they relate to moral, ethical and fiscal concerns.

As has been stated already today, the fastest growing segment of our population is an elderly segment older than 85 years of age. In Pasco County we anticipated a doubling of that population between 1989 and 1993. This group presents the greatest needs of an aging society. The growth projections indicate a growing dependency by this group upon families and nursing homes—families that are incapable of caring for the elderly in some cases because of change in demographics and nursing homes that sometimes lack the funding

or the skills in providing direct patient care as the diseases and illnesses that they treat become more and more complex.

We know and understand that families are still the primary caregivers for the elderly in 1990. I think the figure earlier was 80 percent of the caregiving that goes on, goes on in the home, but this fact will change as sons and daughters in their 60s and 70s will have to care for aging parents in their 80s and 90s. Longevity will create a new series of problems in caring for the elderly who are much older and may require a different approach in service provision and funding by Federal, State and local resources.

We have a good service delivery network in Florida and particularly within the Tampa Bay area with quality human service agencies and effective regional planning efforts on behalf of the elderly. Additional funding is certainly needed to address this area's ever-increasingly elderly population in real terms—more importantly to address the significant aging of the existing population and the special service delivery network that is capable of providing for these special needs. The Federal Government must take a lead role in assuring that individual States meet their obligations in providing for their aging populations. A greater direction of national policy relating to the aging of America must be formulated and implemented at the State level in a joint partnership with the Federal Government.

This Subcommittee on Human Services should review and continually solicit the work of the Florida Pepper Commission on Aging. Additionally, significant thought and effort was directed by the former Florida Committee on Aging during the period of 1984 through 1986 at addressing the issues of our State's older population culminating in a series of "Pathways to the Future" reports. This along with the current State planning document "Better Living for Seniors" gives us directions and recommendations deserved, and hopefully will receive your attention and consideration, particularly as these examine the need for the frail elderly and how those needs can best be matched with existing legislation, both Federal and State. Hearings and testimony is of little value if there is no subsequent response to the needs and direction we need to undertake in providing for an increasingly aging society.

In my professional opinion and based upon a number of years working in the field at the local level in human services, primarily with the older citizens, I do believe we all know what needs and approximate costs are associated with an aging population, particularly in regards to the 85 plus. My concern and question to the subcommittee is, can the political implications be addressed and a unified consensus of commitment be established to really adopt an aging policy that will effectively address the issues related to the frail elderly?

In closing, I want to thank you personally and on behalf of those of us who work in the field of District 5 and of those folks north of here in Pasco County for the invitation to be with you this morning and share my thoughts. Thank you.

Mr. DOWNEY. We thank all the members of the panel. The testimony was very good.

Ms. Gronda, I just have one brief question. You mentioned something about a pilot program dealing with depression in your written testimony. Could you just tell us a little bit more about that?

Ms. GRONDA. That program is what we are using—we are using a screening device which has been developed—really, it is not a funded program. We are using the existing resources of the providers we have in Pinellas County, the skilled counselors who are going into adult day care center and a congregate meal site to identify depression, and hopefully, once this is completed and they find individuals who are indeed depressed and in need of mental health services, we can then get those inhome services to them. We still have not implemented this completely.

Mr. DOWNEY. Thank you. I would like you to keep the committee abreast of the program as it develops.

Ms. GRONDA. I certainly will.

Mr. DOWNEY. Mike?

Mr. BILIRAKIS. Well, in the interest of time, Mr. Chairman, we are going to visit a Neighborly Senior Services Center and the Chairman has to leave for the airport shortly thereafter. I want to express my thanks. Obviously there are questions, but I do want to express my thanks to these good people. It is just—I guess you cannot really ever say anything like, "This is a pleasure," when you are involved with people's needs and whatnot, but if I can, I would like to say it is just great working with all three of you and with members of your staff. And as the Chairman said, keep us advised. I do not know—the Chairman knows better, and I certainly do not want to put him in the position of a yea or nay at this point in time, but I am not sure whether we are talking about being able to do something in the year 1990. I hope we can, but certainly with the reauthorization of the Older Americans Act, we ought to be able to do something, and hearings such as this are very helpful towards that end. But we need your continuous input. We need your actual grassroots stories. You know, I always like to get something like that because everybody can always identify with this particular individual and what his or her problems are and how badly they need this service and how this service has helped them and things of this nature. So I want to encourage you to continue to inform us. And we will certainly share everything with Chairman Downey and with the committee.

Chairman Downey—he did not have to do this. We happen to be in opposite political parties, as a matter of fact, but the point is that he is the Chairman of Human Services of the Select Committee on Aging not only because seniority basically has pushed him to that point. He is chairman because he really cares. I take off my hat to him, and very much, again, express my appreciation for taking time away from his family, I might add, to come down here.

Mr. YOUNG. Mr. Chairman, I think you have been impressed by the testimony that has been presented here this morning by folks who have devoted their life to helping care for America's older citizens and especially those who reside here in Florida. We are very proud of the work that is done here, not only through the folks who work at it full time, but also through the thousands of volunteers that work with them. If you put a price tag on the services that are being delivered through these programs and the volun-

teers, the Federal Government could not afford it, and I think they all deserve a round of applause—all those people who are directly involved and who are volunteers.

Mr. YOUNG. Congressman Downey—I have to tell you, Mike is a very effective Member of Congress. There are times that he and I have debated different sides of issues on the floor, and he is a very effective debater. He does his homework well, but to have a champion like Tom Downey on the issue of health care is a very, very, very positive sign. We appreciate that, Tom.

Mr. DOWNEY. Thank you.

Mr. YOUNG. Also, it is a busy time in Washington, and it is a busy time back in his district, and Mike is exactly right—it was somewhat of a sacrifice for the Chairman to be here, but he is here and we thank him for that. And to my colleague, Michael Bilirakis, Mike, thank you so much for initiating the effort to bring this hearing to our county. The good work that Mike does in Congress is recognized every day by our colleagues in the House, and thank you all very much for being here this morning.

Mr. DOWNEY. You are going to think this is a love-in up here.

Mr. DOWNEY. Mike alluded to the fact that Bill and Mike and I are from different parties, but we want you to understand one thing. We stand shoulder to shoulder in our commitment to the elderly and the needs of the elderly whether they be in New York—and many of my New York constituents are here to visit me today—or here in Florida. It is a pleasure to come down here. I learned a lot, and we are going to learn a little more when we go visit the site. And as I said at the outset of my statement, both Bill and Mike are working full time for you in Washington in making sure that your needs are expressed to all Members of Congress, and you should be very grateful for the work they do in Washington on your behalf. I am as well.

This is not exactly hardship duty to come down here, I might add, in March, and maybe we can make it an annual trip.

Mr. DOWNEY. With that sentiment, the subcommittee stands adjourned.

[Whereupon, at 11:25 a.m., the hearing was adjourned.]

10814

STATE OF FLORIDA

OFFICE OF THE AUDITOR GENERAL

*** PERFORMANCE AUDIT ***
OF THE

COMMUNITY CARE PROGRAMS FOR THE ELDERLY
ADMINISTERED BY THE
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

January 27, 1987

10814

STATE OF FLORIDA

OFFICE OF THE AUDITOR GENERAL

PERFORMANCE AUDIT OF THE

COMMUNITY CARE PROGRAMS FOR THE ELDERLY

ADMINISTERED BY THE

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

Dated: January 27, 1987

Supervised by:

Martha G. Wellman
Program Audit Supervisor

Made by:

Julie A. Ferris
Assistant Program Audit Supervisor

STATE OF FLORIDA

OFFICE OF THE AUDITOR GENERAL

CHARLES L. LESTER, C.P.A.
AUDITOR GENERAL

TELEPHONE:
904/488-5534
S/C 278-5534

January 27, 1987

The President of the Senate, the Speaker of the
House of Representatives, and the
Legislative Auditing Committee

I have directed that a performance audit be made of the community care programs for the elderly administered by the Department of Health and Rehabilitative Services. The results of the audit are presented to you in this report. This audit was made as a part of an ongoing program of performance auditing by the Office of the Auditor General as mandated by Section 11.45(3)(a), Florida Statutes.

Respectfully yours,

Charles L. Lester

Charles L. Lester
Auditor General

600 SOUTH CALHOUN STREET ■ POST OFFICE BOX 1735 ■ TALLAHASSEE, FLORIDA 32302

PERFORMANCE AUDIT
OF THE
COMMUNITY CARE PROGRAMS FOR THE ELDERLY
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PERFORMANCE AUDIT
OF THE
COMMUNITY CARE PROGRAMS FOR THE ELDERLY
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DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

Report Abstract

In this audit, we reviewed the system for delivering community-based services to the elderly. As part of this review we determined the extent to which the Community Care for the Elderly Program offers a cost effective alternative to nursing home placement. We also reviewed the administrative structure for all community-based programs for the elderly to determine the extent to which it:

- Is efficient; and
- Integrates and coordinates services for the elderly at the local level.

We found that the program improves the quality of life for elderly persons and appears to reduce the State's cost of long-term care. However, the cost effectiveness of individual client services cannot be determined due to deficiencies in the Department's cost data. We recommend that the Department continue to revise and improve its methods for collecting program costs and that unit cost data be maintained in a client-specific form.

An impediment to maximizing the cost effectiveness of community services is an additional layer of administrative costs, which is duplicative. In order to maximize the use of program resources, we recommend that the Legislature and the Department seek changes in the Federal regulations that would allow the Department to contract directly with Lead Agencies and eliminate Area Agencies on Aging. In rural districts, it may be necessary for the Department to continue to contract for coordination and planning functions if the Lead Agencies were unable to assume these responsibilities. In other service districts, the Area Agencies could compete for Lead Agency designation and assume Lead Agency functions.

We also found several deficiencies in the Department's management and administrative systems that limit the coordination and integration of services:

- Inaccuracies and duplication between the Department's manual and automated reporting systems;
- An inability to trace individual, multi-service, multi-provider clients within the local service system; and

- Weaknesses in the assessment instrument for evaluating and comparing clients' impairment levels.

The Department is working on plans to solve its data system problems and is currently testing alternative approaches to improve the management and administration of local service systems. We recommend that the Department continue these efforts. In addition, we recommend that:

- The Department conduct a systems analysis to define information needs at all levels of program operation and to determine the best methods for correcting system problems.

- The Department work to develop centralized systems at the local level for tracking multi-service, multi-provider clients.

- The Department improve its assessment instrument to more objectively determine client impairment levels.

PERFORMANCE AUDIT
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I DESCRIPTION AND BACKGROUND

Program

(1) Programs to assist elderly persons are represented at the local level by a service continuum offering services ranging from the highly restrictive, such as nursing homes, to the least restrictive, such as services delivered in the home. Community-based services fall among the least restrictive services offered in the continuum. Programs offering these services are designed to assist older persons in leading reasonably independent, dignified lives in their own homes or the homes of relatives or caregivers. A primary objective of these programs is to avoid unnecessary institutional placement. While this is seen by policymakers as a means of improving the quality of life of the elderly, these alternative placement programs are also emphasized as a means of reducing the costs of long term care.

(2) Community services for the elderly are funded primarily through three enabling laws:

1. Title III of the the Federal Older Americans Act of 1965.

2. The State Community Care for the Elderly Act.

3. Federal and State Medicaid legislation, particularly the Federal Omnibus Budget and Reconciliation Act of 1981.

(3) Title III of the Older Americans Act establishes the basic foundation of community-based services for the elderly. The Act underwent major revisions in 1973 and 1978 that expanded the nutrition and community support services elements of the Federal program. It is through Title III that most of the Act's money is appropriated and spent. The State receives this money in the form of a grant that requires a 25 percent match of State money to the Federal government's share of 75 percent.

(4) Title III provides funds for nutrition and support services. Nutrition services include congregate and home delivered meals. Supportive services include health support, consumer education, and recreational, homemaker, counseling, or referral services. Also included are transportation, housing, and legal assistance.

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(5) Title III also contains provisions for the planning, advocacy, and coordination of services for the elderly and funds these functions through a mandated service delivery system. Services funded solely by the Older Americans Act do not have financial eligibility requirements, nor do they require that recipients be impaired. These services are available to any persons aged 60 or older.

(6) The Community Care for the Elderly Program acts as a supplement to the Title III programs. Section 410.024(2), Florida Statutes, requires that the service providers use all other funding sources before using community-care-for-the-elderly funds. The services offered through community care programs are similar to and augment those offered through Title III support services.

(7) Eligibility for the Community Care for the Elderly Program is more restrictive than eligibility for the Title III programs in that persons must be aged 60 or older, but must also be classified as functionally impaired. As required by Section 410.023, Florida Statutes, impairment is determined through a functional assessment of the person applying for the services. Funds for this program are provided from State general revenue.

(8) Section 410.0241, Florida Statutes, requires that there be one Community Care Service System in each of the Department of Health and Rehabilitative Services's 11 service districts. This system must include case management and at least three of the following core services: homemakers and chore services, respite care, adult day care, medical transportation, mini day care, home delivered meals, health maintenance services, emergency alert, home health aids, home nursing, personal care, and medical therapeutic services. While every county does not offer a full continuum of community care services, as of fiscal year 1984-85 each of Florida's 67 counties offered at least a core continuum of services.

(9) The Medicaid program is funded by approximately 56 percent Federal money and 44 percent general revenue money. The program provides funding for nursing home care for eligible clients. Medicaid clients are diverted from nursing homes to community-based services through two programs:

1. Home and Community-Based Services
2. Comprehensive Assessment and Review for Long Term Care Services (CARES)

(10) The Federal Omnibus Budget and Reconciliation Act of 1981 allows the Secretary of Health and Human Services to waive the Federal Medicaid requirements to enable states to provide community services for Medicaid eligible persons. A determination must be made that persons eligible for these waiver services otherwise qualify for and would receive nursing home placement.

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The case plan for these clients must also include a determination that expenditures for waivered services will not exceed the cost of nursing home care.

TABLE I-1

COMMUNITY CARE PROGRAMS FOR THE ELDERLY
EXPENDITURES FOR FISCAL YEAR 1985-86

Program	Expenditure
Community Care for the Elderly (CCE)*	$24,021,434
Comprehensive Assessment and Review for Long-Term Care Services**	984,541
Title III - Older Americans Act:	
Area Agency Administration*	3,622,915
Services*	37,477,942
Total	$66,106,832

SOURCES: (*) Aging and Adult Services and (**) Medicaid Program Office, Department of Health and Rehabilitative Services.

(11) Community-based services covered under Medicaid waiver services include: case management, respite care, personal care, home management and homemaker services, health support, placement, and escort services.

(12) Eligibility for Medicaid-waivered community services is similar to the Community Care for the Elderly Program, aged 60 and over and functionally impaired. However, these clients must also meet financial income standards; clients must be eligible to receive Supplemental Security Income. In Florida the monthly income standard to receive Supplemental Security Income is $356 or less for an individual. Eligible Medicaid clients are referred to the Community Care for the Elderly Program to receive services. The Community Care for the Elderly Program is reimbursed for these services by the Medicaid program.

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(13) Medicaid eligible clients are also channeled into home- and community-based care through the Comprehensive Assessment and Review for Long Term Care Services (CARES) project. This is currently a demonstration project that operates in specified areas of the State. Clients in these areas who apply for nursing home care receive a comprehensive assessment completed by an interdisciplinary team (doctor, nurse, and social worker). The team will, whenever possible, select home or community-based care over nursing home placement. The Medicaid program is responsible for the client assessment. Services are provided through the Community Care for the Elderly Program and reimbursed with Medicaid funds.

Organization

(14) Section 410.011, Florida Statutes, designates the Department of Health and Rehabilitative Services as the State agency responsible for administering all Federal programs for the elderly appropriated through the Older Americans Act of 1965 and subsequent amendments. Other sections of Chapter 410 establish the Department's responsibilities for State-funded community programs for the elderly including the Community Care for the Elderly Program.

(15) The Department of Health and Rehabilitative Services was created by the Governmental Reorganization Act of 1969. The head of the Department is the Secretary who is appointed by the Governor and confirmed by the Senate. William J. Page served as the Secretary from February 28, 1986, until January 5, 1987. Gaylen Jungling was appointed Acting Secretary on January 6, 1987.

(16) The Secretary appoints three assistant secretaries to head the three major offices of the Department. (See Chart I-1, page 8.) Each of these major offices is responsible for performing a set of related activities or functions for all of the programs operated by the Department. These offices and their responsibilities are:

- The Office of Administrative Services is responsible for providing administrative and management support services above the District level and monitoring such services in the Districts and for establishing Department standards and procedures for the following functions: finance and accounting, grants management and disbursement, purchasing, and personnel services.

- The Office of Program Planning and Development is responsible for coordinating, planning, and developing standards for all of the Department's programs. This office includes seven program offices; each office is responsible for a separate health or rehabilitative program or programs.

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- The Office of Operations is responsible for the daily administration and operation of all of the Department's programs. Under it, 11 District Offices manage and operate programs within their service districts. Each district office is headed by an administrator appointed by the Secretary. District administrators are responsible for assuring that all programs within the district are administered according to Statewide service plans developed in the Office of Program Planning and Development.

(17) Two organizational entities within the Department are designated as primarily responsible for administering community services for the elderly: the Aging and Adult Service Program Office and the District Offices. Neither of these entities provides community services for the elderly. The Department contracts for services through the Area Agency on Aging in each district. Each Area Agency in turn contracts with a Lead Agency for actual service delivery. In some cases, Lead Agencies sub-contract some services.

(18) The Aging and Adult Services Program Office operates under the Office of Program Planning and Development and is the unit responsible for developing all Department policy concerning older persons and implementing the programs mandated through the Older Americans Act of 1965 and the Community Care for the Elderly Act. Specific responsibilities include:

- Developing the State Plan on Aging;
- Designating the Area Agency on Aging in each district;
- Developing an allocation plan for Older Americans Act monies;
- Developing the standards, policies, and procedures for programs for the elderly;
- Monitoring to assure that programs meet standards;
- Providing technical assistance; and
- Providing staff training.

(19) The District Offices operate under the Office of Operations. Programs for the elderly are administered through the District Offices. District Office responsibilities include:

- Reviewing and making recommendations concerning the selection of the Area Agency on Aging and approving an Area Plan;

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- Monitoring the program performances and final operations of the Area Agency on Aging to assure program quality and contract compliance; and

- Reviewing applications approved and funded by the Area Agency to assure compliance with State and Federal regulation.

(20) The Aging and Adult Services Program Office is responsible for designating an Area Agency on Aging in each service district. Designation of an Area Agency occurs through a competitive grant application process. Once designated as the Area Agency, the Agency's responsibilities include:

- Developing an Area Plan;

- Planning for, advertising, and approving funding for lead agencies;

- Contracting for Lead Agency and core services pursuant to the Area Plan;

- Monitoring and evaluating program performance and fiscal operation of contracted agencies;

- Providing technical assistance to Lead Agencies;

- Coordinating all service provider activities; and

- Serving as the general advocate for older persons in its service area.

(21) Area Agencies maintain their designation as long as they meet their contractual responsibilities. Failure to do so gives the Department the authority to designate responsibilities to a new Area Agency.

(22) The Lead Agency is to provide case management services to all Community Care for the Elderly clients and ensure coordination and integration of services for all service providers. Lead agencies also provide or contract for all Older Americans Act service programs according to the Area Plan. Specific responsibilities include:

- Ensuring that all available funding sources have been exhausted before using Community Care for the Elderly funds;

- Providing at least one core service;

- Compiling all reports as required by the State program manual;

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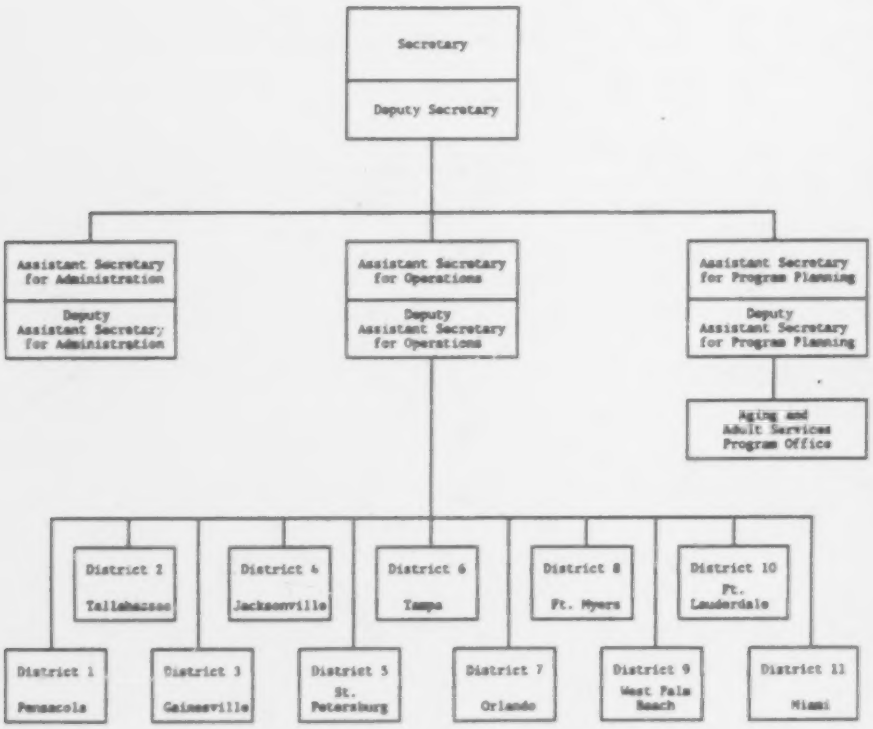
- Collecting contributions and fees for core services;
- Monitoring case management functions;
- Monitoring all subcontractors to assure providers meet all State and Federal requirements; and
- Providing in-service training to the staff of local service providers at least once a year.

(23) The State supports 681 full-time equivalent positions for the Aging and Adult Services programs. Thirty-eight of these positions are with the Central Program Office, and 643 positions are located among the 11 District Offices.

CHART I-1

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
AGING AND ADULT SERVICES PROGRAM
ORGANIZATION CHART



SOURCE: Department of Health and Rehabilitative Services.

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II AUDIT PLAN

Scope and Objectives

(24) Performance audits are conducted by the Office of the Auditor General as part of the Legislature's oversight responsibility for public programs.

(25) In this audit we evaluated community-based programs for the elderly. Our audit focused on the cost effectiveness of the Community Care for the Elderly Program and the efficiency of the administrative system used to provide community-based services to the elderly. We also examined how effectively community services for the elderly are coordinated and integrated at the local level as required by Chapter 410, Florida Statutes.

Methodology

(26) Our audit was made in accordance with generally accepted governmental auditing standards and accordingly included appropriate program performance auditing and evaluation methods.

(27) We reviewed the pertinent sections of the Federal laws, Florida Statutes, and Florida Administrative Code that provide the authority and responsibility for community service programs for the elderly. We collected and analyzed documents and reports from the Department of Health and Rehabilitative Services' Aging and Adult Services central and district program offices, Area Agencies on Aging, and Lead Agencies. We conducted interviews with staff of the Legislature, Governor's Office, and the Department's Aging and Adult Services Program Office, Medicaid Program, and Community Mental Health Services Office to determine their interpretation of the objectives of community service programs. We visited five of the Department's 11 service districts and reviewed district program operation of community services for the elderly. In conjunction with our field review, we interviewed the Department's district staff in Aging and Adult Services, Medicaid, and Community Mental Health Services, and the staff of Area Agencies on Aging and Lead Agencies to determine how service delivery was integrated and coordinated. The field review was also used to analyze the administrative functions of the Department's district staff, the Area Agencies, and the Lead Agencies.

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III GENERAL AUDIT CONCLUSIONS

(28) In general, the Community Care for the Elderly Program is meeting two of its primary program objectives:

- To improve the quality of life for elderly persons; and
- To reduce the total cost of long-term care by avoiding unnecessary institutional placement.

(29) A third objective of the program is to develop approaches to program management and service delivery that encourage cost effectiveness and program efficiency. To meet this objective Section 410.0241, Florida Statutes, requires that the Department fund a service system that coordinates and integrates all community services for the elderly. We found that current management systems do not provide for the effective integration and coordination of community services for the elderly or for the accurate determination of the cost effectiveness of community services for individual clients. We also found that the program's administrative structure could be made more efficient and thereby reduce program costs.

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IV FINDINGS AND RECOMMENDATIONS

The Community Care for the Elderly Program Offers a Cost Effective Alternative to Nursing Home Placement.

(30) Florida Statutes provide in Chapter 410 that the primary intent of the Community Care for the Elderly Act is "to assist functionally impaired elderly persons in living dignified and reasonably independent lives in their own homes or in the homes of relatives or caregivers. . ." In addition to improving the quality of life of elderly persons, the legislation supports two other program objectives: to reduce the use of nursing home care and to develop management systems that promote cost effective service delivery.

(31) We evaluated the extent to which the program achieves these three objectives. We found that community care improves the quality of life of elderly persons and appears to reduce the costs of long-term care by diverting eligible clients from nursing home care. However, we could not determine whether the community services received by individual clients offered the most cost effective mix of services due to the deficiencies in the way the Department collects cost data.

(32) The Community Care for the Elderly Program clearly improves the quality of life of its elderly clients. According to surveys done by the Department, community care clients have expressed a high degree of satisfaction with program services. The Department also found that community care services had a positive impact on reducing stress experienced by those providing informal care for impaired elderly persons. By supporting informal care givers, the program serves to promote the system of private care encouraged by the Legislature of maintaining functionally impaired elderly in community settings.

(33) Although the primary purpose of the Community Care for the Elderly Program is to protect the quality of life for impaired elderly, the Legislature also emphasizes cost avoidance factors in service delivery. The Legislature requires the Department to evaluate the costs and benefits associated with program operation in relation to the extent that community care services reduce inappropriate placement in and use of nursing home services.

(34) As the following table shows, on a per-client basis, the cost of Community Care services is less than the cost to the State of maintaining nursing home patients.

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TABLE IV-1

AVERAGE PROGRAM EXPENDITURES PER CLIENT

	Community Care for the Elderly			Nursing Home		
Fiscal Year	Clients Served	Expenditures	Average Expenditures Per Client	Clients Served	Expenditures	Average Expenditures Per Client
1981-82	15,178	$ 9,687,826	$638	38,608	$ 76,592,831	$1,984
1982-83	21,177	14,796,481	699	40,657	88,886,728	2,186
1983-84	23,978	17,848,848	744	41,591	113,290,647	2,794
1984-85	24,664	21,018,779	852	44,558	127,308,734	2,857

Notes: Clients served are unduplicated client counts. Expenditures per client are not adjusted for variations in length of stay and therefore are not equal to average cost per year per client. Expenditures are General Revenue Funds only.

Sources: Community Care data from Aging and Adult Services Program Office. Nursing Home data from Medicaid Office of Program Analysis.

(35) In order to determine whether or not the Community Care For the Elderly program reduces State expenditures for long-term care by diverting nursing home eligible elderly from nursing home care, data is needed on how many clients would be in nursing homes if community care were not available. However, one difficulty in making this determination is the inability of present assessment instruments to effectively identify the degree to which a person is at risk of nursing home placement. Department evaluations have found that the program does divert clients who are assessed as nursing home eligible from nursing home care and thus concludes that the program reduces the cost of long-term care. However, these conclusions have also been accompanied by qualifications due to deficiencies in the data used in the analysis. Various Departmental studies have reported diversion rates from 38 to 78 percent. Cost analyses done by the Department in 1981, 1982, and 1984 indicated that improved methodologies and more accurate assessment of clients are needed before the diversion rate can be accurately estimated.

(36) The problem of accurately assessing a client's degree of risk of nursing home placement is particularly difficult because not all persons eligible for nursing home placement would accept nursing home services. A 1983 report by the Department's Inspector General on the Medicaid program's Comprehensive Assessment and Review for Long Term Care Services (CARES) points out that there is a certain amount of diversion from nursing homes

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that occurs without any intervention programs. A Department official called this the "natural" diversion rate. A Florida State University survey of Florida's 75 and older population found that 20 percent of those surveyed said they would not enter a nursing home under any circumstances. This resistance to nursing home placement results in a diversion of potential nursing home patients that would occur even if community care were not available. The Department has not estimated this natural diversion rate for the State as a whole.

(37) We attempted to evaluate the cost effectiveness of the program by compensating for some of these problems. In order to make a conservative estimate of cost savings we used the Department's lowest estimate of the number of elderly diverted from nursing homes (38 percent), and reduced it by an estimate of the natural diversion of persons from nursing home enrollment. The 38 percent diversion rate was based on an evaluation of community care clients who had no informal support system and who met special impairment rating criteria (could not perform 2 or more Activities of Daily Life or 3 or more Instrumental Activities of Daily Life). We used the 20 percent figure from the survey results as an estimate of the natural diversion rate and reduced the 38 percent figure by this amount. This gave us an estimated diversion rate that can be attributed to the Community Care for the Elderly Program of 30.4 percent. We then looked at how much the State would have paid in general revenue for nursing home care if 30.4 percent of the Community Care for the Elderly clients, which would be about 7,500 people, went to nursing homes to receive care. Using the State's average per-client expenditure for nursing home care, we found that placing these clients in nursing homes cost the State approximately $21,421,900, which is about $400,000 more than the State expended for the entire Community Care for the Elderly Program. Furthermore, our estimate of potential nursing home expenditures are probably low because the 20 percent figure we used as a natural diversion rate applies to the total population over 75 years old and not just nursing home eligible persons. Given 1984-85 average per-client expenditures for community care and nursing home services, the costs avoided by a real diversion rate of just under 30 percent would equal the costs of the Community Care for the Elderly Program.

(38) While we were able to conclude that the Community Care for the Elderly Program is cost effective, we were not able to determine whether the actual services delivered to clients offered the most cost effective mix of community care services. Assessments of service cost per client are limited by the use of aggregate data in the calculations of cost savings (i.e., total client counts and program expenditures). To do an accurate cost analysis on individual client services we must identify individual clients and apply unit service costs to get actual service cost per client. Accurate unit cost data for community care services, however, is not available from Department records. Studies done by the Department's Office of Inspector General in 1982 and 1984

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have pointed out deficiencies in the present unit cost reporting system. One problem is that the criteria for reporting cost data are not consistent for all providers; any cost comparison between providers is, therefore, potentially inaccurate. This is especially important because community care clients often receive multiple services from multiple providers. Without accurate unit cost data, we could not determine which of the community care services were the most cost effective and whether each client received the most cost effective mix of services.

(39) The Community Care for the Elderly program appears to be cost effective given the most conservative estimates of nursing home diversion. In addition, the program is effective in helping functionally impaired elderly persons stay in their homes, and studies indicate that it improves their quality of life. Therefore, we recommend that the Community Care for the Elderly program continue to be funded by the Legislature as an alternative placement for nursing home care.

(40) In order to be able to evaluate the cost effectiveness of services delivered to community care clients, we recommend that the Department continue to revise and improve its methods for collecting information on program costs, and that the unit cost data be retrievable in a client-specific form.

The Present Administrative Structure for Community Services for the Elderly, Which is Required for Federal Funding, Duplicates Local and District Bureaucracies and Increases the Cost of Program Administration.

(41) Chapter 410.011, Florida Statutes, designates the Department of Health and Rehabilitative Services as the State agency responsible for administering Federal programs appropriated through the Older Americans Act of 1965. The purpose of these programs is to establish, operate, and coordinate a local system of community services for elderly persons. In order to ensure that the operation of these programs takes place within a coordinated service system, resources are allocated through grant applications that serve as planning documents for the State and local planning and service areas.

(42) In addition to the planning function mandated by the Older Americans Act, the Act also prescribes the service system by which these resources are allocated from the State agency to the local service areas. The Older Americans Act requires that the Area Agencies on Aging allocate federal aging resources to the service providers by contracting with them for services in accordance with the Local Area Plan. In addition to these responsibilities, Area Agencies are intended to act as advocates for the elderly in their service districts and to encourage direct service development. The Area Agencies on Aging were not intended to be direct service providers although Federal regulations allow for exceptions. None of the Area Agencies in Florida currently provide direct services.

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(43) This system established by Federal program requirements was in existence prior to the reorganization of the Department of Health and Rehabilitative Services in 1975. However, when the Legislature decentralized service delivery and assigned the functions and responsibilities of the District Offices, those functions and responsibilities closely replicated those of the Area Agencies. Usually when the Department contracts for services, the Department's District Offices contract directly with service providers. For services for the elderly, the Department uses the system established by the Older Americans Act and contracts for community-care-for-the-elderly services through the Area Agency on Aging.

(44) Both Federal and State program regulations identify efficient, cost effective service delivery as a program objective. We examined and evaluated the system for administering community-based services to the elderly to determine whether it represented the most efficient and cost effective system for service delivery. We found that, in general, the Department is not dissatisfied with the performance of the Area Agencies. In the five districts we visited and reviewed we found only one case where the Area Agency had received an unsatisfactory review by the Department. Aging and Adult Service program staff indicated this was the exception; in general the Area Agencies are meeting the Department's performance objectives. However, we found a consensus among staff of the central office and five districts that using the Area Agencies as the contracting agencies for community-based services creates duplication in district and local level functions, and adds to administrative costs.

(45) In our review of district operations we found that some duplication exists in monitoring and planning responsibilities. This duplication occurs in the monitoring activities of the Central Program office, district offices, and Area Agencies and the planning activities of Area Agencies and Lead Agencies.

(46) Fiscal and programmatic monitoring functions are performed by staff at the Aging and Adult Services Program Office, Department District Offices, Area Agencies, and Lead Agencies. Aging and Adult Services staff and District Program Office staff both monitor the activity of the Area Agency. The Area Agency monitors the activity of the Lead Agency, and in some districts the District Program Office staff co-monitor the Lead Agencies with the Area Agency. This co-monitoring is optional and is done to ensure that Area Agency staff adequately monitor service providers. The Lead Agency in turn monitors sub-contracted service providers.

(47) Planning is performed primarily by staff at the Aging and Adult Program Office, Area Agency, and Lead Agency. The Lead Agency makes a grant application for funds to the Area Agency. Although the Lead Agency is not formally designated as a planning agency, this application contains a plan for services to meet the needs of the elderly population in that county. The Area Agency

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develops an Area Plan to meet the needs of the elderly in its region. Most of the State's highest concentrations of elderly are located in service districts of one or two counties. In these cases the Area Plans are essentially county-level planning documents covering services within the area of responsibility of the Lead Agency. These Area Plans are approved by the Department's District Office and go on to the central Aging and Adult Program Office. The Aging and Adult Program Office, using input from the Area Agencies and District Offices, formulates the State Plan.

(48) While some duplication in responsibilities occurs in the present organizational structure, the most prevalent duplication is primarily one of bureaucracy. Each organizational entity conducts monitoring, planning, contract management, fiscal, and personnel functions. In the case of the Area Agency and the District Program Office, these bureaucracies exist at the same level, and the Area Agency represents an additional layer of administration. Such duplication of function and staffing results in higher administrative costs. Dollars that could be spent on providing services to the elderly are spent unnecessarily on administration.

(49) According to the legislative intent of the Community Care for the Elderly Act, the development of "innovative approaches to program management, staff training, and service delivery that have an impact on cost avoidance, cost effectiveness, and program efficiency shall be encouraged." (Section 410.022, Florida Statutes.) In addition, sound management practice holds that organizations should be structured to promote the most efficient communication and coordination between organizational entities.

(50) Given the Department's responsibilities for program oversight and the need for direct service providers, it appears that eliminating the Area Agencies from the current administrative structure represents the most logical method of avoiding administrative duplication.

(51) After reviewing the program operation at the district and county levels, we could make no determination that Area Agencies were actually needed to ensure adequate program coordination. The Area Agencies perform administrative and management functions. They plan, coordinate service delivery, and monitor the performance of service providers for that service district. In addition, Area Agencies often perform advocacy and fund-raising functions. However, Lead Agencies also perform these same functions at the county level where service delivery actually occurs. There are service continuums for community-based services for the elderly in each of Florida's 67 counties. Areas where coordination is a particular concern are the highly populated, high demand, urban service areas: Districts 5, 6, 10, and 11, which cover the Tampa-St. Petersburg area and the Miami-Ft. Lauderdale area. These two areas account for 51 percent

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of the State's population of persons 65 and over. District 10 is one county. Districts 5 and 11 are two-county districts. Coordination between service continuums is not a local problem; the problem is coordinating service providers within the continuum. In these areas the Area Agencies are not able to address the real coordination problems of their service areas without duplicating the role and responsibilities of the county Lead Agencies. The service continuums at the county level seem to provide the more logical focal point for planning, coordination, and advocacy.

(52) Furthermore, the Department's District Program Offices are in a good position to assume the district-wide planning, coordinating, and monitoring roles of the Area Agencies. The District Program Offices currently handle the district-level administrative functions and contract for community services under programs such as Community Care for Disabled Adults, Displaced Homemakers, and Domestic Violence. If the Department assumes the monitoring functions of the Area Agencies, it will need to continue to improve its monitoring efforts, but its focus will be on the Lead Agencies. Audit report No. 10664, issued March 10, 1986, reported that improvements are needed in the Department's monitoring of Area Aging Agencies. In response to that audit report, the Secretary of the Department said that corrective actions were being implemented. While it is reasonable to assume that the District Offices would need some additional staff to perform the administrative and contracting functions now done by the Area Agencies, at least the Area Agencies' supervisory staff could be eliminated.

(53) Local planning and coordinating functions that are presently assigned to the Area Agencies could be shifted to the county Lead Agencies. As we noted earlier, the Lead Agencies are planning for meeting the community service needs of the elderly through their grant applications to the Area Agencies. According to the Lead Agency Directors we interviewed, their agencies are very visible in their communities and are active in soliciting and developing private sector resources. Lead Agencies coordinate services for their clients through case management. They also monitor sub-contractors who provide services not provided directly by the Lead Agencies. Thus, the Lead Agency staffs are already functioning in many of the areas of responsibility of the Area Agency. With some additional positions, Area Agency responsibilities for planning and coordinating local services could be assumed by the Lead Agencies on a level that is closer to actual service provision.

(54) Removing the Area Agencies from the aging organization and dividing their responsibilities between the county Lead Agencies and the Department's District Program Offices would allow funds currently spent on administration to be shifted to delivery of services. The importance of maximizing the application of available funds to the actual delivery of services is underscored by the fact that the Department estimated that in fiscal year

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1984-85 only 27.65 percent of the elderly needing Community Care for the Elderly services were receiving them. Federal funds for administration were reduced 4.3 percent in the 1985-86 fiscal year. The prospect of further funding cuts in Federal Title III Older Americans Act programs could put even more pressure on the primarily State-funded Community Care for the Elderly Program. In order for Community Care for the Elderly, Older Americans Act, and other programs providing services to the elderly to reach the maximum number of clients in need, total costs per unit of service should be kept to a minimum. In order to do that, the costs of administering the programs should be minimized.

(55) The Area Agencies provide no direct services to the elderly. According to the Department's State Plan, the administrative cost (excluding program-related expenditures) of the 11 Area Agencies exceeded $3.6 million in State and Federal funds in fiscal year 1984-85. While State general revenue funds make up only 10.7 percent of this total, the diversion of Federal funds spent on Area Agency administration into Older Americans Act services would benefit the same client population as is being served by the Community Care for the Elderly Program. Furthermore, it is likely that this administrative cost will continue to rise. In its 1985-87 budget, the Aging and Adult Services Program Office requested $625,625 for fiscal year 1985-86 to contract with Area Agencies to administer the Community Care for the Elderly Program. (The Legislature allocated approximately $165,000 of the amount requested.) The Department's request was made due to changes in the Federal classification of program coordination and development funds resulting in a change in the needed Federal/local match for program administration from a 90/10 to a 75/25 ratio. The Program Office was concerned that Area Agencies would be competing with local service providers for local funds. To avoid this, Department staff believe it is necessary to increase the allocation of general revenue to fund program administration to prevent the loss of Federal funds and strain on local resources.

(56) Removing the administrative layer represented by the Area Agencies is in keeping with the historical functioning of the Department of Health and Rehabilitative Services. The district offices are established to implement Department programs either through providing or contracting for direct services. Prior to fiscal year 1983-84, local Mental Health services were contracted through District Mental Health Boards, similar in function to the Area Agencies. The 1984 Legislature amended the statutes, giving the Department responsibility for contract management, monitoring, evaluation, and technical assistance. The Boards are now advisory planning councils. A Department official estimated that the recent elimination of the contracting responsibilities of District Mental Health Boards resulted in a savings of $450,388 in the fiscal year 1985-86 Community Mental Health Budget. The District Mental Health Boards were funded at approximately $1 million a year, a little less than one-third the rate of the Area Agencies.

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(57) Elimination of the Area Agencies could result in more funds being applied to actual service delivery. By conservatively estimating the number of staff positions that could be eliminated, along with reductions in travel, building rental, communications, and utilities cost, we found that a net amount of more than $1.3 million of annual program administrative cost could be saved.

(58) Current Federal regulations require that funds be allocated locally through the Area Agencies. However, an official in the Federal Administration on Aging acknowledged in a recent discussion that a number of states have expressed the desire to eliminate the Area Agencies because of their costs and the fact that they compete with local aging agencies for local resources. He stated that reauthorization of the Older Americans Act Program takes place in 1987 and requests for changes in the Federal law should be addressed during that time. Therefore, we recommend that the Legislature and the Department request a change in Federal regulations to allow states to eliminate the requirement that Federal funds be administered through Area Agencies. Eliminating this requirement would give the Department the flexibility needed to develop a more cost effective administrative system, while still retaining some of the benefits of Area Agency functions and expertise. In rural districts, the Department could continue to contract for coordination and planning functions if Lead Agencies were unable to assume these responsibilities. In other service districts, the Area Agencies could compete for Lead Agency designation and assume Lead Agency functions.

(59) In the event that Federal regulations are changed, we recommend that the district-wide administrative and contracting responsibilities of the Area Agencies be transferred to the Department's District Offices. All other Area Agency responsibilities should be assigned to the Lead Agencies. The Lead Agencies would retain their present case management function.

(60) With this re-assignment of responsibilities, additional resources need to be allocated to the local Lead Agencies and District Program Offices. However, we believe the reorganization will result in a cost savings due to the elimination of some positions such as executive director, assistant director, fiscal supervisor, and other supervisory and administrative staff positions that are duplicated at the local and District Office level.

Undeveloped Management Systems Have Inhibited the Implementation of a Formal Community Care Service System.

(61) Coordination of services for the elderly is mandated by both the Older Americans Act and the Community Care For the Elderly Act. Developing a local community system for elderly services was part of the Older Americans Act mandate in order to capitalize on local activism and volunteerism. Both the Federal

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and State programs for community services recognize that the key element to making service provision work is the coordination of resources.

(62) Section 410.0241, Florida Statutes, requires the Department to fund in each district, and in each subdistrict where practicable, at least one Community Care Service System. The Community Care Service System is defined as a service network comprising a variety of home delivered, day care, case management and other services for functionally impaired elderly persons. These services are provided by several agencies under the direction of a single community-care-for-the-elderly Lead Agency. The Statutes require that the Community Care Service System coordinate all Federal, State, and local programs for the elderly including financial assistance services such as food stamps, Medicaid, Medicare, and other community services. In addition, the Department is required to evaluate the progress of the community care service systems.

(63) The Area Agencies are required by both the Older Americans Act and Community Care for the Elderly Program to plan for a comprehensive and coordinated system of services for older persons. The Lead Agency has the responsibility to coordinate services and provide case management for clients.

(64) Focusing programs on the local community level creates unique and very diverse systems. According to a 1982 study done by the Department, each local service network is determined by the particular configurations of services made available to clients and by the particular arrangements for coordinating and supplying those services. 1/ Major factors affecting the development of each continuum of care include geographic location (urban vs. rural), administrative relationships among programs, population characteristics, program eligibility requirements, and funding requirements. This diversity of types of configurations of local service systems increases the need for and adds to the complexity of coordinating services.

(65) We attempted to evaluate the extent to which the statutory mandates requiring coordination and evaluation of community care service systems had been implemented. We found that the Community Care Service Systems are generally informally coordinated with no formal mechanisms in place to allow for evaluation. Factors contributing to our inability to evaluate the current service system that we found are:

1/ Continuum of Care for Aged and Disabled Adults: An Aging and Adult Services Issue Paper, Department of Health and Rehabilitative Services; December 20, 1982.

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- The inability to track multi-service, multi-provider clients within the local service system; and

- Weaknesses in the assessment instruments used to evaluate and compare clients' functional impairment.

(66) Keeping records of client referral activities is important to determine the extent to which client services are coordinated and to help case managers arrange for unduplicated services. As a means of evaluating coordination, we decided to review the referrals made at the district level to determine the extent to which clients received services from different providers and different programs. However, we were unable to evaluate coordination by using client referral data because this data is not available. Lead Agencies do count and report the number of referrals made to and from their agency, but this data is not client-specific. None of the Lead Agencies, Area Agencies, or District program offices kept district-wide, client-specific referral logs or systematically recorded and documented client referrals. Thus it was not possible for us to document client-specific referrals as a measure of coordination of services.

(67) While we were unable to evaluate program coordination through client referral data, the Department has identified several important components that should be present to assure coordination of services. We reviewed the community service system for the presence of these coordinating mechanisms. Department Program manuals and staff identify the following as important components to coordinated service delivery:

- The presence of central information and referral functions;

- Cross-training of program personnel;

- Local coordinating councils;

- Resource directories; and

- Formal memorandums of agreement which specify the responsibilities of each party for providing and coordinating client services.

(68) The Community Care for the Elderly Program Manual provides that a Community Care Service System should provide access to services for clients most in need, and it should provide coordinated delivery of services via a continuum of care to respond to clients as their needs change. These same manuals dictate that in order for a system to operate effectively it must

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be highly visible and accessible to prospective clients. The 1984-86 State Plan on Aging states that access to services such as information and referral and outreach is the key to a maximum utilization of all available resources.

(69) The degree to which these coordinating mechanisms were established varied among the districts we reviewed:

- We found through our reviews of district operations that most communities do not have central information and referral systems to ensure adequate access to services, nor do they maintain adequate referral records to be used to track clients within the system. Some cities and counties do have telephone counseling and referral services that include aging information among other community information, but these systems are not administered by the Area Agency or the local Lead Agency and are not comprehensive.

- Of the five districts we visited, two of the Area Agencies conducted cross-training programs.

- We found only one county in one district had a formal local coordinating council. We found that most metropolitan areas have informal organizations of service providers that meet regularly.

- We found every district had some type of community resource directory, usually published by a local social service agency.

- The existence of formal memorandums of agreements ranged from one or two legally required agreements with other agencies to written agreements with a large number of local organizations and providers.

(70) Overall, we found that local networks operate primarily on an informal basis and most have not developed the reporting systems necessary to evaluate the coordination and integration of service delivery. Our observations and discussions with district and local program staff are supported by the Department's 1985 Community-Care-for-the-Elderly Evaluation. The results of surveys of Lead Agencies and providers showed the most frequently reported type of relationship among service providers was informal. This report also states that the biggest barrier to coordination in urban areas offering many services is inter-agency communication problems. We were often told that the informal systems depend on the enthusiasm and commitment of project directors and case managers. Not all of the program managers we interviewed believe that the informal systems create any impediments to coordinating services. However, most program managers expressed concerns over

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the lack of coordinating systems and saw this as an impediment to effective program management. Formal procedures will not guarantee effective coordination of services. However, the lack of formal procedures increases the potential for inadequate coordination.

(71) The second problem we found involves the assessment of client impairment levels. Objective and measurable assessment of client functional impairment is central to determining program effectiveness and matching existing resources with service needs. A portion of the Department's responsibility for planning and funding the Community-Care-for-the-Elderly Program includes the development of mechanisms and systems that can be used to assess clients. We evaluated the client assessment function and found that while the Department has developed a standard assessment instrument for the program, this instrument is not used for evaluating all potential community service clients. It also does not provide adequate indicators of the client's impairment level that allow program staff to assess the program's effectiveness at diverting clients from nursing homes.

(72) The vast majority of impaired elderly clients are assessed according to the HRS-AA Form 3003 used by both Aging and Adult Services units and the Community Care agencies. A second assessment instrument, the Geriatric Assessment Testing and Evaluation System, is used by the Medicaid units participating in the Comprehensive Assessment and Review for Long-Term Care Services Program. This assessment is used for clients applying for nursing home admission. These two forms do not use the same indicators or scoring methods and cannot be compared to determine level of impairment.

(73) A common complaint among program staff about the 3003 form was that the scoring methods do not provide accurate indicators of a client's impairment level. The procedures manual sets priorities for clients to be served based on client assessment. The 3003 form consists of two different parts: a questionnaire and a section of categorical ratings. The questionnaire is completed during an interview between the case manager and client where information is collected from the client concerning his physical and mental health and environment. When the questionnaire is completed, case managers then rate clients from 1-5 on categories of impairment that include physical health, self sufficiency, social supports, activities, environment, financial, personal adjustment, and intellectual functioning. According to the program manual, all categories are to be weighted evenly. However, program staff indicated some categories such as physical health may be more important than other categories. In addition the scores reflect the individual case manager's judgment on the interpretation and significance of the client's responses on the general assessment instrument. Program staff consistently agree that the instrument scoring indicators are inadequate and cannot be used to accurately compare the impairment levels of clients in different programs. Furthermore, the categorical score

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cannot be used to assess a client's degree of risk of nursing home placement. Thus it provides limited assistance in evaluating the program's success at preventing nursing home placement.

(74) In a 1985 survey conducted by the Department's Office of Evaluation and Management Review of State administration of long-term care programs, the assessment instruments of other states were reviewed by evaluators. Two instruments were found to incorporate useful assessment factors not found in Florida's assessment instrument. One instrument covers concrete tasks that can be verified. These types of indicators were found to be important predictors of outcome and service needs according to an evaluation of a Florida demonstration project. A second instrument converts the responses to numerical scores. These scores are then used to determine the level of care needed by the client. This helps to eliminate the subjectivity of the rating scales used in the Florida instrument.

(75) The Department's efforts to develop the management systems used to assess clients and coordinate and integrate service delivery have been constrained by several factors:

- According to Department evaluation staff, due to the emphasis since 1980 on expanding community care services Statewide, resources have been directed at establishing core services in each county, not at establishing formal management systems. It was not until fiscal year 1984-85 that every county provided at least three core services.

- In fiscal years 1981-83, the Department's budgets were reduced due to Federal reductions and general revenue shortfalls.

- According to District Program Office staff, budget limitations have contributed to deficiencies in staff training and high personnel turnover. We found in our district reviews that the majority of program staff receive only on-the-job-training in using the client assessment form. A recent evaluation by the National Association of Public Administrators of the Department shows a 22 percent turnover rate in Human Services Counselor II's, a position used to staff Aging and Adult service units.

(76) The Program Office is aware of the deficiencies in the management and coordinating systems for community-based services. The Program Office is conducting various projects around the State to improve coordination of resources and services. These efforts are contained within two grant projects: Community Service System grants and a Unified Administrative System grant.

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(77) In response to concerns expressed by the Governor's Florida Committee on Aging regarding the current fragmented service delivery approach, the Department funded four Community Service System projects. The intent of these projects is to improve the integration of service delivery. Although they each differ, the projects provide for the development of mechanisms for coordination of services, and centralized outreach, intake, and assessment functions. According to the overview of the grant project written by the Aging and Adult Services Program Office, the Community Service System projects will reaffirm the original intent of Chapter 410, Florida Statutes, that requires a community care service system. The four projects have been funded in fiscal year 1985-86 with continuation funding planned for fiscal year 1986-87.

(78) The Unified Administrative Systems project speaks directly to the administrative and program specific requirements that make coordination difficult. The project's goal is to develop a unified administrative system model suitable for replication throughout the state. The specific objectives of this project are to implement cross-agency case management and client tracking systems and to develop a common service taxonomy, a comprehensive client profile form, resource directories, and uniform application and eligibility procedures. The Program Office asserts that a Unified Administrative System will be more efficient and will provide greater accountability.

(79) The current grant projects appear to address many of the deficiencies in the current service system. We recommend that the Department continue these projects and, based on their results, develop Statewide applications and mechanisms that can be applied at the local level to improve both the service delivery and program evaluation. We recommend that these systems include client tracking, centralized information and referrals, centralized recording of client referrals within and among programs, and a uniform assessment instrument that can be used across programs to more objectively assess a client's impairment level.

The Department's Automated Data System Is Not Accurate Enough to be Used in Management and Budgetary Decisions and Is Not Responsive to the Providers' Information Needs.

(80) Information and reporting systems are an integral part of any program's planning, budgeting, and evaluation functions. Chapter 410, Florida Statutes, requires the Department to evaluate the progress of the community care service system. The objective of this evaluation is to assess the program's ability to reduce inappropriate placement and the use of institutional services. To effectively meet this requirement, reliable information that accurately measures client impairment levels and documents service use and eligibility is needed at all levels of program administration.

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(81) We reviewed the Department's information systems to determine whether the methods of collecting and reporting data are efficient and the system meets the information needs of program staff and service providers. We found that the Department has established an information system that collects data used to evaluate community care services and has taken steps to improve its information system through automation. However, we also found that:

- The automated system is inaccurate and does not provide service providers with useful management information.
- The data collection requirements and use of manual and automated systems to collect the same data are inefficient.
- A comprehensive systems analysis of the data and reporting needs of all levels of program operation has not been performed.

(82) Section 10A-10.05, Florida Administrative Code, requires agencies receiving Community Care for the Elderly funds to maintain client, fiscal, and program records and to provide reports as required by the Department, at least on a quarterly basis. Two systems, one manual and the other automated, are currently in place to collect and report this information to the Aging and Adult Services Program Office.

(83) The manual reporting system has existed since the Statewide implementation of the Community Care for the Elderly Program in 1980. The system comprises primarily two reports: the Monthly Program Analysis Report and the Quarterly Output Report. For both reports, service data is collected by providers, compiled by the Lead Agency, aggregated by the Area Agencies, and reviewed by the District Program Offices. The data are then forwarded to the Central Program Office.

(84) The automated reporting system is part of the Department's Client Information System. Two input documents are used to collect the data for the Client Information System: the Client Information Form and the Daily Service Log. The Client Information Form is filled out once the client has been determined to be eligible for community services and is then updated only as changes occur. The service logs summarize services that community care clients received each month. However, to meet Federal Medicaid reimbursement requirements, the logs must show the services Medicaid clients receive each day. Both of these input documents are submitted to the Department's Management Services data entry sites within the districts. These units enter the data from the documents into the Client Information System.

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(85) The manual and automated reporting systems collect essentially the same information: client demographics, client assessments, referral sources, and services received. The manual system, however, reports client data in the aggregate; it is not client-specific. As of July 1, 1985, the Aging and Adult Services component of the automated system was redeveloped, and providers began reporting program and service data that is client-specific. According to Department planning documents, the impetus for this system redevelopment came when the previous data and reporting system were found to be inadequate in detail, accuracy, and scope to perform an analysis of the long-term care system mandated by the 1984 Appropriations Act.

(86) The automated Client Information System was supposed to replace the manual reporting. The manual system, however, has not been phased out because the Client Information System data is inaccurate. In June 1986, the program office staff compared the data produced by the manual and automated systems. They found a 35 to 39 percent error rate in the data produced by the automated system. The error rate varied for individual districts and reporting categories; some districts had little if any error, others had significant error rates. The Program Office found that all districts were reporting client age and ethnicity accurately, but many districts had errors in the unduplicated client count, client attrition, and service data. The Program Office plans to eliminate the manual report requirements when district error rates drop to five percent or less.

(87) In an effort to identify and remedy the causes of inaccurate data, in July 1986, the Program Office reviewed a random sample of Client Information Forms and Daily Service Logs to be entered in one district with a high data processing workload. Program staff found several reasons for inaccurate data:

- Providers were not filling out the data forms correctly.
- Providers were submitting the forms late or not at all.
- District data entry units were making errors.
- District data entry units had high backlogs.

(88) Program staff believe that providers fill out the forms incorrectly because they have inadequate staff training and quality control procedures. The providers' failing to submit forms or submitting them late is attributed by both program staff and providers to two factors:

- The Daily Service Logs require staff time to duplicate information already recorded in other documents, and

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- The automated system does not give providers useful management information.

(89) Although providers must comply with the Department's reporting requirements, it is difficult to get them to take the time necessary to supply data for a system that does not meet their information needs. Lead Agency and Area Agency staff told us that the daily service logs are particularly time consuming to fill out and duplicate information they already have in client files. One Lead Agency Director expressed frustration with spending so much time filling out forms that could be better spent in service provision. Furthermore, most of the Lead Agency and Area Agency directors we interviewed said that the Client Information System does not provide them information they can use to manage their programs. Program office staff told us that the system was primarily intended to collect the client service data needed to develop the Legislative Budget Request. Consequently, the system was not designed to meet the management needs of providers.

(90) While providers are responsible for some data inaccuracies, backlogs and data entry errors in the district office also contribute to the high error rate. Program staff attribute data entry errors and backlog to understaffed data entry units and insufficient training for data entry personnel. In some District data sites entry staff positions were not increased commensurately with the expanded data entry needs of the information system. According to program staff, other district offices do not have funds to provide adequate training programs.

(91) Problems of data entry backlog could be alleviated by increasing the uploading capacity of the automated system. Uploading is the ability to electronically transfer data directly from a mini computer to a mainframe computer. Approximately one-third of the program's providers have their own computer systems. Currently, data generated through the providers' computer systems must be printed out and then manually input into the Department's computer because the software that would allow for electronic transfer of the data has not been developed. The data system plans made by the Program Office include developing this uploading capability. According to the plans, this would eliminate thousands of data entry hours each year and would substantially decrease the inaccuracies caused by data entry error and backlogs.

(92) Streamlining data forms and reporting requirements may increase provider participation in the automated information system. Program Office staff recognize this and have suggested simplifying reporting mechanisms. Program Office staff also recognize the inefficiency in maintaining both the manual and automated reporting systems and the problems and limitations of the automated system. The Program Office is attempting to correct system problems and increase system capacity. Included in its

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program budget request are increases in data system capabilities that will address problems in the current system. The Program Office has proposed two types of systems:

- Expand and enhance the present system of centralized data collection; increase the system's ability to produce ad hoc reports; develop a microcomputer network that electronically links providers to district data entry who in turn upload data directly into the mainframe; and

- Develop a microcomputer system where the client-specific data base is maintained at the provider level; information is reported in the aggregate and electronically transferred from the district office to the Central Program Office.

(93) Basically, the same information is collected by both systems. The difference is primarily one of a centralized data base versus a decentralized data base. However, we could not evaluate the proposed systems because the Aging and Adult Services Program Office has not conducted a comprehensive systems analysis to determine the amount of information needed at the various levels of program operation. Staff within the Program Office have differing views as to the need for reporting client-specific data to the Central Program Office. Given this difference of opinion within the Program Office and that both systems appear to address the same problems, it appears unwise to proceed with systems development without a comprehensive systems analysis. Without this analysis the Program Office cannot determine which approach best suits current needs and is most cost effective.

(94) Therefore, we recommend that a comprehensive systems analysis be done that identifies the information needs of all levels of program operation. We also recommend that this analysis be used to determine the most cost effective method of achieving those needs, and whether a decentralized or a centralized system is the optimal alternative.

(95) Efforts should also be made to explore streamlining current methods of collecting and recording client and service information. As part of the analysis of information needs we recommend that the Department, in conjunction with service providers, analyze reporting needs and develop reporting systems that more efficiently use the information routinely collected for each client. This would decrease the reporting workload demands currently placed on providers and would possibly ensure better compliance with reporting requirements.

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V RESPONSES FROM THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES AND THE FLORIDA ASSOCIATION OF AREA AGENCIES ON AGING

In accordance with the provisions of Section 11.45(6)(d), Florida Statutes, a list of preliminary and tentative audit findings was submitted to the Secretary of the Department of Health and Rehabilitative Services for his review and reponse.

The Secretary's written response is reprinted herein beginning on page 32. Also reprinted herein is a written response from the Florida Association of Area Agencies on Aging. Where necessary and appropriate, Auditor General's comments are inserted in the body of the latter response.

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

January 16, 1987

Mr. Charles Lester, C.P.A.
Auditor General
State of Florida
Holland Building
Tallahassee, Florida 32301

Paragraphs in Audit Report

Dear Mr. Lester:

Thank you for the very comprehensive performance audit of "Community Care for the Elderly Administered by the Department of Health and Rehabilitative Services." Your audit findings and recommendations provide an important perspective on a set of issues which are highly complex and broad in nature.

The response of the Department of Health and Rehabilitative Services to the report and findings is as follows:

Response to Recommendation Paragraph 39

(30-40)

The department agrees that community care is a cost effective alternative and will continue providing the legislature data to support expansion of the program.

Response to Recommendation Paragraph 40

The department agrees that we should continue to revise and improve methods for collecting information on program costs. This agency has recently refined the unit cost reporting methodology. An implementation plan will be developed to further this effort and incorporate the auditor general's recommendations.

Response to Recommendation Paragraphs 58 and 59

(41-60)

While the recommendation is very complex, the department agrees that the entire system of aging services needs to be analyzed. The department recognizes Florida's rapidly changing demographics, the impact of changes in the federal and state policy and funding of health and social services, and the concommitant need for a service delivery system that effectively accommodates these changes.

The department supports recommendations that the Older Americans Act be revised to allow flexibility for states to develop organizational structures that are efficient, responsive, cost-effective and best meet the needs of local communities.

Paragraphs in Audit Report

Response to Recommendation Paragraph 79

(61-79) The department agrees that statewide application of successful demonstrations or components of demonstrations is appropriate. Adequate funding will be required for expanded systems development.

Response to Recommendation Paragraph 94 and 95

(80-95) Although the department recognized in 1984 that the information systems needed improvement and expansion, corrective action did not include a comprehensive systems analysis because of time and resource constraints. The review process for systems requirements specifications and various work groups was substituted, in an attempt to obtain multi-level, broadly based expertise in finalizing system requirements. Also a micro-computer network demonstration was sought and initiated using federal discretionary funds. With reference to medicaid waiver earnings, there have been significant increases in earnings resulting from these data system improvements and monitoring improvements.

However, the department agrees that resources should be sought to reevaluate and then readdress the continued improvement and efficiency of the information systems. Considering the unusual aging demographics of Florida, accurate, useful, timely, and accessible information is essential. The department has plans to consolidate manual and automated systems, and will incorporate these into the action plan in response to this report. Further, the department agrees that the systems analysis should incorporate local evaluation of data needs, resources, and potential for improvement.

Our Office of Aging and Adult Services has sent copies of this preliminary report to HRS district program offices, the state advisory council for aging and adult services, and the area agencies on aging. Responses are anticipated. An information copy was also sent to Florida International University Center on Aging which is currently performing a study on the state's long term care system. We will specifically plan to follow-up on each of the recommendations as we continually search for ways to improve services to clients in Florida.

Thank you for the opportunity to comment on the preliminary report.

Sincerely,

Gaylen Jungling
Acting Secretary

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

January 16, 1987

Mr. Charles L. Lester, C.P.A.
Auditor General
State of Florida
Holland Building
Tallahassee, Florida 32301

Dear Mr. Lester:

Attached is a copy of a letter received from the Florida Association of Area Agencies in response to the Auditor General's Performance Audit of Community Care for the Elderly. Your office had informed our Office of Aging and Adult Services that you would accept one letter of comment from the 11 area agencies.

Thank you for your consideration.

Sincerely,

Gaylen Jungling
Acting Secretary

GJ:MLD:jm/m

Attachment

Copy to: Judith G. Thames, President
Florida Association of Area Agencies

1317 WINEWOOD BLVD. • TALLAHASSEE, FL 32301

Bob Martinez, Governor

January 5, 1987

Margaret Lynn Duggar
HRS Aging & Adult Services
Program Staff Director
Bldg. 2, Room 328
1323 Winewood Blvd.
Tallahassee, FL 32301

Re: Auditor General's Preliminary Findings for Community Care for the Elderly

Dear Margaret Lynn Duggar:

The Auditor General's preliminary report on the state of the Community Care for the Elderly Program has been revieved by Florida's Area Agency on Aging (AAA) Directors. Initial comments expressed concern at the extremely short turn around time alloved for reviev and response. The report vas not received by AAAs until December 24, 1986 with comments due in Tallahassee by January 6.

Auditor General's Comments

The Preliminary and Tentative Audit Findings were delivered to the auditee (the Department) and by law, the Department had 30 days to respond. The response time given the Association was determined by the Department.

Of primary concern is the portion of the report devoted to the functions of Area Agencies on Aging (AAA) as part of the Aging network. Florida's eleven Area Agencies on Aging are federally mandated through the Older Americans Act. Its citizen's-controlled administrative structure insures that planning, service delivery, and local funding allocations will be conducted from the private, local community level upvard, rather than bureaucratically dovnvard.

AAA vere designed with the flexibility and fluidity, to respond to the input of Seniors and Senior Advocates; to develop comprehensive community-vide plans for services based on local input; to develop and coordinate additional community resources to meet senior needs; and to serve as advocates for elderly persons. Area Agencies, as community-knovledgeable leaders for

senior concerns, have served successfully as conduits for developing Older Americans Act programs at the local level and in garnering and coordinating local resources for community-wide service programs. As part of a 665 aging nationwide network, federal and state policies and initiatives are generally adopted and pursued as part of the AAAs local work programs.

In Florida the additional responsibilities for Community Care for the Elderly (CCE) increased the ability to develop and coordinate a more comprehensive network of senior services. The inclusion of Home Care for the Elderly in this network would additionally enhance planning and coordination capabilities as successfully demonstrated in the Jacksonville model project.

We are pleased to note that the preliminary report indicates the State is satisfied with the AAAs performance. However, we are concerned that the auditor general's report does not fully represent the multiplicity of activities of AAA in Florida as it did not encompass the full range of the functions and services that AAAs provide. Since the study was conducted only in urban counties, it does not appropriately describe the situation in rural counties. Nor does it describe the effectiveness of most AAAs program development and coordinating activities. Area Agency personnel provide State and community visibility and input on the concerns of the elderly through their participation on local citizen and agency boards and committees. AAA staff have also developed an on-going working relationship with the media, in disseminating information on the needs and concerns of older people.

As the report states , HRS, CCE lead agencies and AAAs perform some similar functions. It is noted that this duplication was HRS' decision as Area Agencies were in existence before HRS decentralization and District offices were established. Local, citizen input suggested that HRS handle Protective and Adult services and allow AAA to administer elderly programs. Utilizing the existing federally funded staff of AAAs, HRS could have avoided the current duplicative functions of monitoring and aging contract management performed by both CCE lead agencies and district offices. AAAs are experts in these functions and are contracted by the State to perform them.

When CCE was established with passage of Chapter 410 to provide services to functionally impaired elderly, HRS designed and developed policy which perpetrated duplicate functions through the separate lead agency concept. AAAs already performed these duties to all elderly. Does this indicate responsiveness to cost effectiveness?

The Auditor General's recommendations that CCEs as lead agencies assume AAA functions in community planning, coordination, and program development, demonstrate a lack of comprehensiveness in the audit of both CCE's and AAA's abilities and functions. AAA's again are experts in these areas.

Auditor General's Comments

We would like to clarify the focus of our audit in this area:

- Our audit fieldwork did include visits to two primarily rural districts; and
- Our audit did include an analysis of Area Agency functions. We did not evaluate the performance of the Area Agencies themselves.

The primary issue in our finding concerning the administrative system for aging services is one of duplication in administrative function. The Association asserts that duplication exists as a result of decisions made by the Department. Given the oversight responsibilities for both Federal and State Aging programs delegated to the Department by the Legislature, we concluded that the Department could not meet these responsibilities through central office oversight alone. Our decision to recommend a change in the Federal regulations that would allow eliminating the Area Agencies was not based on a finding that Area Agency functions were unnecessary but that these functions can be performed by the Lead Agency and the Department's District Offices. We found nothing in our review or in this response that identifies functions that, given additional resources, could not be performed by these two entities.

The report raises more questions than it answers:

- Would local governments continue to supply match for services run by a State Department. Local government units providing match say no.

- AAA's have administered CCE programs with no administrative funds. The CCE $15,000 per AAA allocated for the past two years is specifically for program development and coordination involved in the CSS system. This amount is .0053% of the $30million plus total CCE allocation. Would this be the same cost if HRS administered it?

- Is the immediate cost savings beneficial over time? One AAA alone generated over a million dollars for $350,000 in agency costs. Another developed a low cost housing facility for the elderly while others generate community resources on a regular basis.

- Is HRS responsive to community and individual needs?

- Do lead agencies recommended to take over AAAs planning and coordination functions have the capability, vision, and desire to conduct and execute community-vide, long-range planning and develop the linkages and cooperation necessary to implement those plans without negatively impacting service delivery?

-Would local agencies respond to efforts of lead agencies to coordinate all services on behalf of seniors or see only self interest by a competing direct service organization?

- Is the expansion of the HRS bureaucracy in the best interest of the senior population?

- Is the State prepared to lose $50,000,000 in Older Americans Act service funds if AAAs are removed while Federal regulations continue to mandate them?

- Who is capable of making a more immediate response to needs of the elderly, HRS or a local citizen's agency?

Auditor General's Comments

Our recommendation is to seek changes in Federal regulations that would allow the Department to restructure program administration. This in no way jeopardizes the State receiving Federal funds for elderly services. We would like to emphasize that our recommendation was made in order to reduce administrative costs to increase the amount of funds devoted to services.

In summary, while the aging service system may need some strengthening, it is important to be ever cognizant of the impact on those persons we are here to serve - - the elderly. AAAs have demonstrated expertise as resource developers as well as innovators in implementing programs which respond to the needs of the older, frailer persons we now serve. It's obvious from the report that the CCE program, administered solely by the AAA since it first received general revenue funding, has been found by the auditor general to be a cost effective program and successful alternative to more expensive nursing home placement. It would appear from the report that Area Agencies have performed their administration functions most competently with minimal cost to the State. Should success be replaced?

In addition we have demonstrated ability to plan comprehensively, to serve as leaders in community coordination and develop the resources and linkages necessary to provide a service network for Florida's 2,697,054 senior population.

It is recommended that a more comprehensive evaluation of the AAA be conducted to determine ways in which duplication could be minimized while retaining the strength of both HRS and Area Agencies on Aging.

Sincerely,

Judith G. Thames

Judith G. Thames, President
Florida Area Agency on Aging Association

JGT:jkv
ORG1/auditor-
CC: Auditor General
F4A Membership
District Service Providers

MICHAEL BILIRAKIS
9TH DISTRICT, FLORIDA

COMMITTEE ON ENERGY AND COMMERCE
Energy and Power
Health and the Environment
Oversight and Investigation

COMMITTEE ON VETERANS AFFAIRS
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Compensation, Pension and Insurance

CHAIRMAN, TASK FORCE ON
THE ELDERLY
CONGRESSIONAL HUMAN RIGHTS CAUCUS
ENVIRONMENTAL AND ENERGY STUDY
CONFERENCE
TRAVEL AND TOURISM CAUCUS
TASK FORCE ON CRIME

Congress of the United States
House of Representatives
Washington, DC 20515-0909

March 5, 1990

PLEASE RESPOND TO:

☐ WASHINGTON OFFICE
1530 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0909
(202) 225-5755

DISTRICT OFFICES:

☐ 1100 CLEVELAND STREET, SUITE 1900
CLEARWATER, FL 34615
(813) 441-3721

☐ 2739 U.S. HWY. 19, SUITE 110
HOLIDAY, FL 34691
(813) 947-1932

☐ 600 WEST REVIRD STREET
SUITE 1077
PLANT CITY, FL 33566
(813) 752-9360

Dear Friends,

I would like to thank you for attending today's Select Committee on Aging Subcommittee hearing on the frail elderly.

As a federal legislator and long-time supporter of Older American programs, I have been encouraging my colleagues in Congress to pass legislation that will ensure that services for the frail elderly will continue to be provided without disruption.

For this reason, I introduced H.R. 1879, a bill designed to establish a new category of disadvantaged elderly for those age 85 and older. It is not my intention to reduce funding levels received by other categories already designated by the Older Americans Act. I simply want the frail elderly to be taken into consideration by states when Older American funds are distributed and, in my opinion, the best way to accomplish this is through federal legislation.

I have also been working on several other projects involving Older Americans. I am fighting to keep the Social Security trust fund off budget, I am seeking to raise the earning limits for Social Security recipients and I am serving as the Chairman of the Task Force on the Elderly. I am continuing to draft proposals for Long-Term Health Care because I believe it is essential to provide custodial coverage to persons afflicted by Alzheimer's and other related diseases.

As you may recall, in the 99th Congress I introduced legislation establishing government demonstration projects to study the feasibility of Medicare reimbursement for Alzheimer's patient day care in appropriate facilities and a national network of Alzheimer's support groups. Additionally, last year I had the opportunity to serve on the Congressional Conference Committee on the Medicare Catastrophic Repeal legislation.

It is my hope that today's Congressional hearing will help to further our shared goals for senior health care, and that is why I appreciate your taking the time to participate.

Sincerely,

Mike Bilirakis

Michael Bilirakis
Member of Congress

JACK M. PETERSON
2866 COUNTRYBROOK DR. NO. 13
PALM HARBOR, FL 33563

MR CHAIRMAN AND MEMBERS OF THE COMMITTEE:

MY NAME IS JACK PETERSON, MY CURRENT TITLE AND VOCATION IS CARE GIVER. I DID NOT SEEK THE TITLE AND I DISLIKE THE VOCATION. I AM A FORMER STATE LEGISLATOR FROM THE STATE OF MINNESOTA AND AM AWARE OF YOUR RESTRICTED TIME, THEREFORE, I WILL BE DIRECT AND TO THE POINT. MY WIFE AND I HAVE LIVED IN PALM HARBOR, FLORIDA FOR THE PAST SEVEN AND ONE HALF YEARS.

FIRST.....

MY PURPOSE IS TO TESTIFY IN SUPPORT OF MENTAL HEALTH SERVICES FOR THE ELDERLY. SPECIFICALLY, I WILL TARGETTHE SUPPORT NEEDED FOR THE SPOUSE AND THE FAMILIES AFFECTED BY ALZHEIMERS AND THE RESULTING DEVASTATION CREATED BY ITS' IMPOSITION.

SECOND.....

TO ILLUSTRATE WHY PINELLAS COUNTY NEIGHBORLY SENIOR SERVICES AND THE GULF COAST JEWISH FAMILY SERVICES ARE SO IMPORTANT TO THE SPOUSE AND FAMILY OR FAMILIES OF THE ALZHEIMER VICTIM.

THIRD.....

A BRIEF STATEMENT ON THE NEED FOR A NATIONAL PROGRAM OF NURSING HOME CARE FOR THE ELDERLY.

MY WIFE IS AN ALZHEIMERS VICTIM. TWO YEARS AGO AFTER A FULL YEAR OF TESTING AND OBSERVATION BY OUR NEURALOGIST HE GAVE US HIS VERDICT OR DIAGNOSOS. IT WAS ALZHEIMERS. OUR DOCTORS FINAL WORDS OF THE DIAGNOSIS WERE, "THERE IS NO KNOWN CURE AND AT THIS TIME THERE IS NO MEDICATION AVAILABLE. WE WERE DEVASTATED AND BECAME VERY DEPRESSED. WE LEFT THE OFFICE WITH NO DIRECTION AS TO WHAT TO DO. WE WERE ON OUR OWN WITHOUT A ROAD MAP. I DIDN'T REALIZE IT AT THE TIME THAT MY EDUCATIONAL TRAINING AND EXPERIENCE HAD NOT SCHOOLED ME IN WHAT WAS NOW TO BE MY FUTURE VOCATION. UNKNOWN TO ME THAT DAY WAS THE

PAGE TWO

FACT THAT I WAS NOW A SLAVE. ACTUALLY I LOST MY WORLD OF FREEDOM AS EACH OF YOU DEFINE THE WORD FREEDOM.

THE FREEDOM TO COME AND GO

THE FREEDOM OF HAVING PERSONAL TIME

THE FREEDOM OF CHOICE TO CHOOSE RANDOM DAILY ACTIVITY

THE FREEDOM OF HEALTH CARE SECURITY. THE WORD ALZHEIMERS IS LIKE LEPROSY TO THEHEALTH CARE INSURANCE SUPPLIERS

THE FREEDOM OF FUTURE FINANCIAL SECURITY

THE FREEDOM TO TRAVEL AS A RETIRED COUPLE

AND I COULD NAME MANY MORE. I WAS NO LONGER IN CHARGE OF OUR RETIREMENT , OUR WELL BEING OR OUR PLANS.

I CALL IT THE MAFIA OF ALL SENIOR DISEASES. WHY? BECAUSE IT NOT ONLY TAKES OVER THE VICTIM BUT ALSO THE SPOUSE, THE FAMILY, AND IT CREATES AN IMPOSITION ON ALL SOCIETY. FATE ENTERED IN, AND I FOUND A COUNTY AGENCY , THE NEIGHBORLY SENIOR SERVICES WHICH POSSIBLY COULD HELP. IN JANUARY OF 1988 SHE WAS ACCEPTED FOR DAY CARE AT THE PALM HARBOR NEIGHBORLY SENIOR SERVICES DAY CARE CENTER. SHE WOULD ATTEND TWO DAYS A WEEK FOR FIVE HOURS A DAY. THIS WAS THE BEGINNING OF A CLOUD WITH A BRIGHTER LINING. I NOW HAD TWO PARTIAL DAYS OF FREEDOM IN WHICH I COULD DO OUTSIDE NECESSITIES. BUT THAT WAN'T THE MOST IMPORTANT PART OF THIS CONTACT WITH NEIGHBORLY SERVICES.. LET ME TELL YOU WHY.

FIRST....

I HAD A CASE MANAGER ASSIGNED TO US AS OUR FIRST MEANS OF SUPPORT

I RECEIVED GUIDANCE AND LEARNED I WAS A CARE GIVER, AND THE IMPORTANCE OF THIS CARE. DO ALL OF YOU REALLY KNOW WHAT A CARE GIVER IS/

I WAS OFFERED AND RECEIVED AN EIGHT WEEK WORK SHOP WHICH TAUGHT ME THE FUNDAMENTALS OF CARE GIVING. IT INCLUDES ALL PHASES FROM THE UNDERSTANDING OF YOURSELF TO THE LEGAL CHANGES THAT TAKE PLACE BECAUSE OF THE DISEASE--TO THE PITFALLS--YES, THE PITFALLS OF CHOOSING A NURSING FACILITY. I LEARNED ABOUT THE MEDICAL PHASES OF ALZHEIMERS, THE CONTROL DRUGS USED FOR THE CONTROL OF MENTAL CHANGE.

PAGE THREE

BUT MOST IMPORTANT I LEARNED ABOUT THE CONCEPT OF THE SUPPORT GROUP THAT IS AVAILABLE IF NEEDED. THIS TYPE OF SUPPORT IS AN ABSOLUTE NECESSITY BECAUSE NOT ONLY IS THERE A VICTIM OF ALZHEIMERS WHICH YOU ARE HERE TO FIND OUT ABOUT, BUT THERE IS A GROUP RELATED TO EVERY ALZHEIMERS VICTIM THAT IS GOING TO BE AFFECTED UNTIL ONE OR THE OTHER DIES. THESE ARE THE FAMILY MEMBERS, AND THE COMMUNITY MEMBERS BUT MOST IMPORTANT THE SPOUSE. THE DISEASE HAS CREATED SUCH COMMUNITY TRADGEDIES AS MURDER, SUICIDE, AND STARVATION. THESE ARE HAPPENING EVERY DAY. THINK OF THE HIDDEN COST THAT HAS BEEN CREATED. THESE TRADGEDIES ARE CONTROLABLE AND YET THEY HAPPEN.

I AM NOT HERE TO BEG.....BUT TO REQUEST YOU AS MY ELECTED REPRESENTATIVES TO HELP EXPAND THESE SENIOR NEIGHBORLY SERVICES TO THE EXTENT THAT THE NAME NEIGHBORLY SENIOR SERVICES IS AN EVERYDAY ACCEPTED SERVICE. KNOWN BY ALL IN THE DOCTORS OFFICES, THE CHURCHES, AND THE BUSINESS PLACE. LET'S MAKE THIS THE CORNER STONE OF ELDERLY CARE AND SERVICES. THIS SUPPORT GROUPS SYSTEM IS THE ONLY WAY TO HELP THE ELDERLY FROM THE START OF OLD AGE TO THE END. THEREFORE, I ASK FOR CONTINUED AND EXPANDED FUNDING FOR DAY CARE, AND ALL THE SENIOR SERVICES THAT ARE INCLUDED IN THE NEIGHBORLY SENIOR SERVICES PROGRAM. IF FOR NO OTHER REASON THAN THE CURRENT STATISTIC, WHICH SHOWS THAT FOUR PERCENT OR MORE OF ALL AGE 65 YEARS AND OLDER HAVE ALZHEIMERS.

THIRD....

ALZHEIMERS IS A DISEASE THAT PROGRESSES IN THREE STAGES. I HAVE CONCLUDED MY POSITION ON THE FIRST TWO STAGES.

THE THIRD STAGE IS THE PERIOD WHEN FULL TIME NURSING HOME CARE IS REQUIRED. THIS IS THE PERIOD OF DEVASTATION TO THE FINANCIAL STATUS OF THE AVERAGE FAMILY.. THE COSTS IN THIS AREA RUN FROM 2500.00 TO 3500.00 PER MONTH. THAT AMOUNTS TO 30,000 TO 41,000 PER YEAR. YOU ALREADY ARE AWARE OF THIS AND I WOULD LIKE TO STATE FOR MYSELF THAT I AM WILLING TO PAY MY FAIR SHARE BASED ON AN ABILITY TO PAYORMULA, FOR NURSING HOME CARE. THIS SHOULD BE A NATIONAL PROGRAM WHICH IS INCLUDED IN A GOVERNMENT HEALTH INSURANCE POLICY. IN CONCLUSION, I HAD NO INPUT IN THE CATOSTRPHIC MEDICARE BILL AND WAS NOT HAPPY WITH IT. THIS TIME YOU HAVE LISTENED AND I THANK YOU FOR THE COURTESY OF GIVING ME THIS AUDIENCE.

Chairman Downey and Congressman Billrakis and subcommittee.

The letters and statements in this package represents thoughts and feelings that come to this public hearing of the House Select Committee on Aging Subcommittee on Human Services on March 5, 1990 from participants, caregivers and/or friends of the Neighborly Senior Services Adult Day Care Programs in Pinellas County, FLorida. Several thoughts were shared with the Florida Pepper Commission on Aging last Tuesday.

The Project Director of the Neighborly Senior Services Adult Day CAre Project is Dale Sklenar, 13650 Stoneybrook Drive, Clearwater, Florida 34622, his phone number is (813) 573-9444, ext. 267.

The center put new life in me. It gave me a reason to go on living and I look forward to my attendance each time I could.

The activities are varied and enjoyable. To suit everyone attending.

We all look forward to the simple games, sing-a-long, and various entertainers who frequently visit us.

The time passes quickly and pleasantly and I look forward to my visit with great pleasure.

I am thankful to my daughter for having persuaded me to try the center just "one time." I am convinced this is the right place for me!

Gratefully yours,
Rose Ferret

age; 94½
born: 8/9/1895

ROSE FERRET
1006 Chatham Court
Safety Harbor, FL 34695

February 22, 1990

My daughter encouraged me to visit the Salve Harbor day care center. After much coaxing I decided to try "one time". I was happily pleased with what I saw. Believe me I was not disappointed!

The attitude of the staff changed my mind. The patients and care the participants received amazed me no end. No favoritism is ever evident, no matter how many requests are made.

For a year pryor to coming to the center I was depressed and hospitalized several times. I gave up hope of ever feeling well again.

I was miserable and

February 22, 1990

It is impossible to imagine the change that has come over my 94 year old mother since she started attending the Palm Harbor Adult Day Care Center.

Mom would sit home depressed, crying and feeling totally unable to cope with life.

With no more living friends and her husband deceased, life was unbearably lonely.

She had to be coaxed for hours to get showered and dressed and usually stayed in her nightgown all day and didn't even want her hair combed.

Now mom tells me to give her her shower and is concerned about her clothes and general appearance on the days she

When I pick mom up at the center, she is eager to tell me about the days activities and what she had for lunch, but most of all how wonderful and "special" she was treated that day.

This is how the center has helped my mother, but beyond that is the difference it has made in our home.

My dad, brother and I can once again be alone for a few hours with no responsibilities. We can go out to lunch without feeling guilty that mom is not being included.

Because of this, I find I don't feel as "angry" all the time because I have to stay home while everyone else is coming and going at will.

We are still tied down

but it is easier to accept
when you know 3 days a
week mom is going to have
something very special to do
with some "very special" people.

Our thanks to Liz, Carol,
Ingrid, Sue, Judy, Louise and
all the volenteers.

Sincerely

Marie & Dick Salvi

Mrs. Richard Salvi
1006 Chatham Court
Safety Harbor, FL 34695

CAREGIVER

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

Selma Day Care
PARTICIPANT

Dear Friend

I enjoy my trips to the Day Care Center. It is very interesting and each day gives us something to look forward to being here. The programs are of a great varied and interesting nature. It is something to look forward to each day. There is no sitting around and looking at four walls. I feel that anyone in our age-bracket would look forward to coming there if they knew about it. Life would be very dull without having a place like this around.

Jess Clark

February 20, 1990

To whom it may concern;

It's been almost a year now since the accident which faced my father-in-law to relinquish his independence and move in with my husband and I.

My father-in-law's condition, following his accident, left us faced with a dilema. As he could walk with the aid of a walker, he did not require the type care associated with a nursing home. However, as his mability was limited, he did require some assistance. My husband and I both work and we were not sure how we were going to care for my father-in-law throughout the day.

The solution to our problem came in the form of Palm Harbor Adult Day Care Center. At this facility my father-in-law is able to do as much or as little as he desires while under the supervised care of a very professional staff. He is able to socialize with other adults his age, partake of nutritious meals, and have the security of knowing someone is there should

he need assistance. Palm Harbor Adult Day Care Center is like a home-away-from-home for these older adults. The comfortable surroundings, programs geared toward the interests of older adults, and family atmosphere are the perfect combination.

As for the staff, we can't say enough about these dedicated people. Under the guidance of Liz Kelly, the elderly, like my father in-law, are treated with the respect and dignity they deserve.

If it were not for a facility like Palm Harbor Adult Day Care Center, my father-in-law would probably be confined to a nursing home. We need more facilities such as this for the care of our elderly.

Sincerely
Barbara O'Hanlon

CAREGIVER

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

9-1-90

To Whom this May concern,

I would just like to tell you how much the Palm Harbor Adult Day Care has meant to me. Let me first say my name is Mae Belle and Lonie Creamer is my Mother. Mom has been going to Day care for over 10 yrs. I really am very sincere when I say I do not know how I could have managed without it. I also know how much it means to my Mom. If it were not for the people there she would just be lost. These are her friends her life line. If she has to stay home a day during the week she is upset. She likes being apart there. She helps with others which helps her. Were it not for the fact that she can go there I would not be able to go out to work. Even then its hard to make ends meet. These people who work there are wonderful with them. Thank God for such a place and love combined for all of those who so need some one to keep and eye on them when family can not. Please help us in anyway you can to keep this place open for older seniors.

Thanks + Thanks again

Sincerely

Mae Belle Weakley

CAREGIVER of
PALM ADULT DAY CARE PARTICIPANT

CAREGIVER

February 26, 1990

To Whom It May Concern,

Due to the death of my father, my mother came to live with my wife and I. Mother is 82 years old and does not always think clearly. To say the least this has been a strain on all of us, we did not feel comfortable leaving mother alone and felt she needed to be out with people in her own age group. When the doctor recommended day care it was and is,a God-send, as now Mother has a place where she is well-cared for, she is able to be around her peers,and the staff helps keep her mind stimulated with many different activities. This gives my wife and I time together and the opportunity to take care of errands involved with every day living. Due largely to the education the public receives concerning health and nutrition,the population of the United States is getting older and older and quality care for the mind and body,particularity in our declining years should be of prime importance to our leaders, We feel we are one of the lucky ones to have found such care for Mom and hope it will be avaliable in the future when we too will need this service for my wife and I.

Sincerely,

Erich C. Albrecht

CAREGIVER

- 2.24.90

Palm Harbor Day Care
Attn: Liz Kelly

Dear Ms Kelly:

I am writing this letter to stress the importance of the Day Care Center to my brother Cecil.

As you know Cecil suffers from Parkinsons disease and the Center is his only chance of being with people his own age and in circumstances similar to his. Each day Cecil gets dressed and sits in the chair, looking out the window waiting for the bus to take him to the center. It is his only outlet for being in touch with other peo, e. Since I work during the week, it would be impossible to be with him, but what a relief for me to know that he is under supervision and care and getting the medication he needs daily.

I cannot express my sincere appreciation enough to the personnel of the Palm Harbor Day Care Center for the care and supervision that they are giving him and hope it would be able to be continued in the future

Sincerely,

Cecil

SENATOR KISER AND MEMBERS OF THE CLAUDE PEPPER COMMITTEE ON AGING

To show the importance of an Adult Day Care Center, I think the best way to do this, is to explain how things have evolved for me and my family.

During a 30 day period, my 94 year old father-in-law lost 30 pounds before we ever knew anything was wrong with him.

He had a "silent" stroke that effected his ability to swallow. I left my home and went to their home in Lakeland to care for him. After a week it was decided to bring him and my mother-in-law to Palm Harbor.

Things continued to get worse for him and myself both physically and mentally as I lost more and more sleep. Finally, I could no longer cope with the situation and sought help from the Center.

At first I used the time that he was there to rest and prepare myself to deal with him when he came home from the Center. In other words to help me, not him!

As time progressed though, my attitude as well as his changed. This is what I meant earlier when I said, "how things evolved" for us.

I now send him to the Center for several reasons.

First, it is for the social interaction with members of his peer group. He looks forward to the music, entertainment, and fellowship. This has lead to him having a better interest in the things around him. There as well as at home.

It is now secondary for him to attend the center for my rest and recuperation.

If it was not for the Palm Adult Day Care Center, Mr. Perry would be in a nursing home at the expense of the United States Veteran's Administration or worse.

Mr. Perry's food is all liquified and he is fed 5 to 6 times a day. This makes caring for him very difficult. This program saves the government that expense and allows Mr. Perry to live in a loving home atmosphere.

The entire staff not only cares for the clients but also teaches the Caregiver how to better help their loved ones.

They conduct regular sessions for the Caregivers. That gives positive reinforcement in the areas where Caregivers need it the most.

There have been times when I was extremely tired and even wondered if I was doing the right thing for him and my family. The Center (the Staff) helps me and my family understand those feelings and we go on with our lives.

But the most important thing that the Center does is to bring SMILES to the clients. You would think that such a Center would be depressing. Let me assure you, that this is not the case. The atmosphere is always pleasant and uplifting for the clients and Caregivers....thanks to the Staff.

I would urge you to continue funding this program for the elderly and to open more such centers across this great state.

If it was not for this Center I do not think Mr. Perry would be alive today; let alone living a life with as much quality as he does now.

Thank you for your time and interest in the caring for the Elderly.

Sincerely,

NORMAN ATHERTON

Commissioner of the Palm Harbor Special Fire Control Commission

CAREGIVER

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

ANNE F. SHINNEMAN (MRS. D.A.)

TO THE HONORABLE CURT KISER

The Palm Day Care Center is answering the need of many Floridians in this area for seniors who have so little left to look forward to.

My mother, Mrs. Mary Huha, is now nearly 88 years old, truly cannot take care of herself, and lives with me for basic care needs (cooking, laundry and bathing). She cannot go out shopping, to the doctor, dentist, clinic or hospital without the help of my husband and myself. She walks with a walker for a short distance. Longer distances require a wheel chair.

Palm Day Care has filled a great need. She is able two days per week to get out of the house under the care of others who can handle her, mix with others of her own age and condition and be encouraged to exercise and have conversation interchange with more than her own family.

She is not alone in this respect but many more need this small amount of socialization and the feeling that someone besides her daughter and son-in-law cares about her.

I urge you to continue support of this program. She has served her working years and support of the social system and needs at least a minimal amount of attention in these waning years.

Sincerely,

ANNE F. SHINNEMAN (MRS. D.A.)
914 Gillespie Drive
Palm Harbor, FL

CAREGIVER

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

3/23/90

Honorable ~~Curt~~ Kiser
Tallahassee, Florida

Dear Senator Kiser:

I write this letter with enthusiasm about the subject of Palm Adult Day Care Center.

I first became aware of the center in 1989 after going through the caregivers program sponsored by the Geriatric Mental Health Support Team of the Gulf Coast Jewish Family Services. About mid-year 1989 I met Liz Kelly, the center supervisor, Carol, assistant center supervisor and the staff. The reason for my interest in the center was in hopes of having respite care for my mother. My mother had been diagnosed with Alzheimer's in Nov. 1987 and it was indeed with cautious but welcomed hope that perhaps Mom could enjoy herself and be well taken care of without my constant involvement. Palm Adult Day Care was the answer to my hopes.

After a joint meeting of my mother, myself

[illegible] Day Care Center, Inc. I
would like to express my appreciation for the effort, encouragement and commitment you have shown and continue to show about Palm Adult Day Care Center. It has been and is a blessing for both my mother and myself.

Thank you for your continued support.

Sincerely,
Mrs. Maureen Schicker, Caregiver
Mrs. Margaret Schatz, P.A.D.C. Adult Participant

PARTICIPANT

CAREGIVER

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

CAREGIVER

452 Wexford Run Blvd
Palm Harbor, FL 34683
Feb 22, 1998

Dear Mr. Kress,

My mother is 89 years of age + required constant attention. The Palm Harbor Adult Day Care Center offers my mother & respite from an attentive monitoring ef-sitters. and gives me a release from the constant care + stress. Without their capable help and loving care, I don't believe I could continue to care for my mother at home.

Sincerely,
Kathy Shea

CAREGIVER

I want to express my appreciation for Neighbor Senior Service program. The respite program is truly a blessing for the caregiver & the people who take charge at the Palm Harbor are very much a caring group, giving all seniors individual attention to make them comfortable & they do enjoy the day.

Thank you for Abraham

Mrs. Helen M. Hott

CAREGIVER

The Neighborly Senior Center keeps my husband's mind active. He reads newspapers. The Center keeps his mind stimulating. He does follow-through with the program at the Center.

It gives me the opportunity to take care of my own problems like dental and medical.

It's a good emotional outlet for me for I am responsible for his total care the remaining hrs of the day.

It's a mental stimulus for him to be able to go somewhere without me, in that it gives him conversation and something to talk about

Mrs. Lemuel Bruning

CAREGIVER

[illegible]
[illegible]
Senate Commission

January 21, 1990

Dear Senator Kiser:

I fully appreciate the great difficulties you and your fellow legislators are confronted with during this period of ever increasing needs for quality human services and the ever decreasing availability of public monies. I am sure that every special interest group you hear from quotes reams and reams of statistics supporting their particular cause. Each of us is convinced that our cause is the most important and therefore the most deserving.

I would like to take just a few moments of your time to make a special plea for my special cause, the PALM HARBOR ADULT DAY CARE CENTER. I would like to describe the importance of this one program in the lives of three people.

My wife's mother lives with us. She will be 87 years old in May, 1990. Five mornings a week the PALM HARBOR ADULT DAY CARE CENTER bus picks her up. While she is at the center she is able to interact with her peers. She is mentally and physically stimulated. She is an integral part of a group. She helps to feed other folks at the center who are more mentally and/or physically disabled than she. She is given a sense of purpose. She feels needed. She has friends who love her and whom she loves in return. The quality of her life is greatly enhanced by her involvement in the activities of the center.

Without the stimulation of the PALM HARBOR DAY CARE CENTER, there is absolutely no doubt in my mind that her physical and mental capabilities would have deteriorated to the point where she would be in a nursing home or some other type of expensive institution.

Her time at the day care center affords my wife and me the opportunity to have a little bit of time together, to recharge our batteries, to run errands and do things together that would otherwise be impossible to do. It gives us the respite we need to continue to cope with a difficult [illegible]

As you can see, my interest in the continued level of [illegible] PALM HARBOR ADULT DAY CARE CENTER is for [illegible]

[illegible] programs to be damaged by any reduction of its public funds.

My wife and I strongly urge you and the members of the County Commission to support and protect the level of public funding of the SOUTH SHORE ADULT DAY CARE CENTER.

Thank you.

Sincerely yours,

John F. O'Neill
[illegible]

Doris E. O'Neill

CAREGIVER

Dear Court Visitor

I wish to express my feelings about the Palm Bay adult care facility. It means a great deal to me as my husband has Parkinsons disease and needs constant supervision. I have no family here to help with his care. He goes to the center twice a week which enables me to do my shopping and other duties that the head of household must do. It also gives me a few hours of respite.

My husband loves to go to the center where he spends time with others like himself. It gives him a purpose in his dull existence. The staff are caring and giving which allows me to leave him without fear. If it should close it would create a hardship for us as I couldn't afford in home help at 10-12 dollars an hour.

It is a shame in a rich country like this that spouses must live in fear that they will become impoverished if their mate has to go to a nursing home. The governing body from the president on down should hang their heads in shame.

Yours sincerely

Laura Denoski

wife of Louis

P.S. I do not agree with the [illegible] that [illegible]

CAREGIVER

Februray 21, 1990

Senator Curt Kiser
121 North Osceola Avenue
Clearwater, Florida 34615

Dear Senator Kiser:

My mother, who is 82 years old, has been going to the Palm Adult Day Care Center for three years. After having several strokes she came to live with me and my family and since I work it is a tremendous relief knowing that she is being well cared for. Not only is she being cared for by those wonderful caregivers, they are so kind and loving, but she is enjoying herself, making new friends, and is informed of the daily news.

Because of her failing eyesight she cannot read. If this center was taken from her I don't know what would happen to her. She really looks forward to going and is up early in the morning on the days she attends the center - looks forward to it, takes pride in her appearance and is happy.

My thanks to all who are responsible for keeping these people content and putting some purpose in their lives.

Sincerely,

Katherine F. Cardalico

Katherine F. Cardalico
288 Lakeview Terrace
Palm Harbor, Florida 34683

CAREGIVER

James A McGee
3434 Zara Way
Clearwater, Fl. 34621

Feb. 23, 1990

Neighborly Senior Services
1500-16th Street
Palm Harbor, Fl. 34683

The Honorable Curt Kaiser;

My father Arthur J McGee, age 94, attends the day center several days a week. My wife and I are in our late 60's and have been care takers to him for 4 years. The day care is a salvation to us and a joy to my father, for he receives companionship when he is there and we receive the support needed so we can carry on our lives.

Aside from the emotional support, there is a financial area that should be addressed. We pay several hundred dollars a month for this service, a small amount compared with the service he receives. If we did not have the Neighborly Senior Services, we would have to place him in a Nursing Home, for we could not cope with his care without a break. He would then be placed there and his bills would have to be paid by Medicaid This would be easier for us and a lesser financial strain to us but as long as we have the service we do not have to take that step.

The personnel at the center are professional and very competent. They are friendly and very caring. They have made our life easier and fuller. I can not say enough about them. My hope is that the service will be there for a long time to come, for this is the approach to care for we old people.

Sincerely,

James a McGee

CAREGIVER

FEBRUARY 22ND. 1990.

PALM HARBOR ADULT CARE CENTRE
TO: THE CARE GIVER

SOPHIE DESOUZA AGE 97 IS MY MOTHER. SHE IS BLIND, LIVES IN HER OWN APARTMENT. SHE HAS BEEN GOING TO PALM HARBOR ADULT DAYCARE CENTRE FOR MANY YEARS. THE CENTRE HAS DONE REMARKABLE THINGS FOR THE AGED. BESIDES TAKING CARE OF THEM, THEY HAVE GAINED THE TRUST OF THEIR CARE GIVERS.

SOPHIE LOOKS FORWARD TO BEING WITH FRIENDS OF HER AGE AT THE DAYCARE AND THE WONDERFUL STAFF THAT MAKES HER COMFORTABLE AND HAPPY.

I HOPE FOR MY MOTHER AND ALL THE PEOPLE AT THE PALM HARBOR CENTRE THAT THE DOORS WOULD NOT BE CLOSED, ENABLING THE HANDICAPPED AND AGED IN OUR SOCIETY TO ENJOY AN ACTIVE AND HAPPY LIFE.

THE PALM HARBOR DAYCARE HAS GIVEN THE ELDERLY PERSON A SENSE OF ACHIEVEMENT WHICH IS A GOOD REASON FOR LIVING.

SINCERELY,

Irvine L. DeSouza

IRVING DESOUZA

CAREGIVER

MEMO February 23, 1990

To: The Honorable Curt Kiser

From: George and Jane Fels, Box 207, Ozona, Fl. 34660

Re: The Palm Adult Day Care Center

We appreciate your concern for our fragile old folks and their caregivers, and for the Palm Adult Day Care Center, one of the few escapes available to us.

George is blind and very dependent. At home he mostly sits in his rocking chair in front of a TV he cannot see nor understand. With the housekeeping chores I must take care of, there is little time for entertainment. He looks forward to the three days a week he goes to the "Center". There are many friendly people there; much moving around; activities he can participate in; old time music to stir up memories; a hot meal with friends at the table; and always there is the knowledge that when it is time, he will go back home.

As for the caregiver, I can relax in the knowledge that he is in a safe and comfortable place; that trained people are caring for him; and that he is content. So I am free to do the dozens of things I need to do. And when it is time for him to come back home, I am glad to see him!

I cannot imagine any arrangement that would be as helpful to us both as the Palm Adult Day Care Center. We sincerely thank you for your help in keeping it open for us.

Jane Fels

(Mrs. George Fels)

To: Whom it may concern

The elderly day care center is special to me because it is a meeting place for my father to socialize with other senior citizens during the day. Prior to enrolling him into the program, my father sat home during the day alone and basically bored.

Just listening to my father each day after he comes home from the center lets me know that he enjoys his daily visits. He has his good days and some bad days, but overall he really enjoys the daily interaction with the other participants as well as the staff.

Hopefully, more senior citizens will take advantage of this program. I think by having a daily schedule, it gives my father a sense of responsibility just as he felt before he retired.

Sincerely,

Ms. G. McCray

[redacted] Caregiver

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

CAREGIVER

To the Honorable Senator Kaiser,

My name is Betty Bauer and I am the only caregiver of my husband, Philipp. He will be 75 years old. He retired in 1990 from the Univ. of Chicago, IL as a manufacturing engineer.

Around seven years ago he had some small strokes and three years ago he had some tests which revealed that he has dementia or Alzheimer. Our world almost came apart.

After many phone calls I enlisted in the Gulf Coast Jewish Family Service Geriatric Mental Health Support Team for Caregiver Training programs which was a lifesaver for me and I learned to try to cope with my husband's illness.

Here I inquired about some [illegible] I was instructed to give me some time to myself and try to [illegible]

[illegible]

Palm Harbor Adult day care center. Not to many Adult day care centers will take anybody with Alzheimer disease.

The staff and nurse are so kind and helpful to him and all the other patients. He likes it there and I do have some time of my own. We do need the Adult Day Care Center. Please help support it in Tallahassee and dont make anymore cuts for the help of our elderly.

All our lives we paid our taxes and helped where we could. Nobody likes to ask for help and now we have to. Please, please keep on supporting our Adult Day Care Center, because we are caregivers and need the support and still try to keep our dignity and sanity.

Sincerely,
Betty Baker

WILLIAM RILEY

69 years old

Wonderful for my spirits.

Makes me feel real good.

Enjoy the activities.

The people that work here are wonderful.

The meals are great.

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

ANGELO MARINI

I came four years ago to this center because my wife has Alzheimers. After I put my wife in a nursing home I was home by myself, so I come everyday. All the staff are so nice. Volunteers nice, too. If it wasn't for this center I'd end up in a crazy house.

I like everything here--food, activities, also bingo.

I hope this place keeps going because otherwise I'd have to stay home and go crazy. As a matter of fact, the place is so clean. We have a 100% janitor who keeps the place spotless!

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

What the Adult Day Care Center has meant to me.....

(1). It has saved my marriage of 44 years.

(2). It has helped keep my sanity.

(3). It has helped keep me in better health. My Mother's health is much better than mine, but she doesn't realize that. She can't remember why I have scars.

(4). My Mother is very interested in going, and looks foward to it. She watches for the bus, and if the bus is a little late, she is asking me "why"?

(5). She tells me the people are all so nice to her but she can't remember their names.

(6). She loves to go and she doesn't like Saturdays or Sundays.

Phyllis Bray

CAREGIVER

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

I am a 70 yr. woman who lives with my brother in Dunedin. I come to the Palm Adult Day Center 5 times a week.

I think the Center is remarkable. I like the fact we all can get together and keep each other company.

I enjoy the programs like singing, crafts and games.

The lunches are very good. They taste good and have a nice variety of food.

Transcribed by Gail Arms for Ann Cetrulo
Ann Macdrulo

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

Bob McCauley - 79

Attending 2½ yrs - 5 days a week.
Center has greatly improved since I first started attending.
There is a well rounded program.
Good meals.
Bus pick-up.
We could use more volunteers to assist the staff.
The aim here seems to be to help others help themselves.

Robert J. McCauley

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

I am a 78yr woman who lives in a ACLF in Palm Harbor I come to the Palm Adult Day Care Center 2x/week. for 9 months.

I enjoy the crafts the most. I recently helped make tissue paper carnations for Valentine's Day. I also enjoy the games. like the card games & dominoes.

the lunches are very tasty and Nutritional. the food is always hot and well prepared.

I enjoy being with ~~people~~. I like people.

I enjoy going on walks with people you like.

I enjoy the guessing games.

Transcribed by Karl Lane for Pat Hill

Pat Gill

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

2/20/90

I am a 80 yr. man who lives with my son + family in Palm Harbor. I attend Palm adult day Center 5 times a week. I enjoy the entertainment especially picnics the food is usually tasty. I think it is very nice.

Transcribed by Hal Arris for John O'Hanlon

John O'Hanlon

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

2/20/90

I am 86 years old and live with my granddaughter in Palm Harbor. I come to Palm Adult Day Care 3 times a week. I thoroughly enjoy the activities, I look forward to the days I come to the Center. I enjoy the activities (singing, music, crafts) and espiciallly enjoy the companionship of the other seniors and the staff.

Transcribed by Paul Ennis for Edith Oldham.

Edith Oldham

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

I am 86 year old woman who lives by myself in Dunedin. I come to the Palm Adult Center 5 days a week. I enjoy the variety of activities. I never get bored. The food is superb. The bus picks me up at my home and the bus ride is very nice. I have made many nice friendships at the Center.

Transcribed by Paul Cuno for Rita Dell'Oglio

Rita Dell'Oglio

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0660

Vinnie Pecoraro - 87 yr old.

Has been attending center for 3 months
was on waiting list.
I think its wonderful, it is like
a free nursing home. I attend 4
days a week.
We have a well rounded program.
Lunches are good + well served.
The girls work very hard + take
good care of us. I call them "Angels
of God."

Vin Pecoraro

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

Elizabeth Eules – 82 yrs old

Has been attending the center for 1 yr., I come 4 times a week.

I really enjoy being here. I live by myself, so this gives me something to do with myself.

I am very happy with everything.

The girls here are the greatest and work very hard.

They take good care of me.

ELIZABETH EULES

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

Nicholas Pagano - 82 yrs old

I've been attending the center for 2 yrs, 5 days a week.

I like it very much. The programs are very good entertainment.

The workers are very attentive, obligining & considerate, and good lookers.

The meals are almost like home cooking.

The medical attention is also very good.

Nicholas Pagano

PARTICIPANT

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

PARTICIPANT

To whom it may concern

Having attended
Dealman day Care for several years.
I find ram ranch ship very
pleasant people to spend a day with
Do so enjoy the walks and card games
We also have a session of sing song here
on the patio.
I find all the staff very courteous
and caring.
The hours are well spent at S.C.D.
Sincerely Hazel Reich.

PARTICIPANT

To Whom it May Concern.

I am Josephine Nowowski having attended 9 yrs at the Lealman Day Care Center.

I enjoy all the people and kind all the caring -

I do enjoy every one at the center Having living alone 10 years. My children are far away from me dont see them very often.

Have to depend on Strangers one of my neighbor has been very good to me. Her name is Dorothy Snow.

We do receive a lot of help at our home from L.D.D.

Sincerely

J Nowowdworski

PARTICIPANT

i come to day care 5 days a week this my
place to be it is to me and my wife to
come to. we have arts + Craft Jobs we
bus servel to from our home to day care
and return kind at 3 Oclock each day
my wife comes 3 days a week too
we have a nurse on duty to watch
us all it is done some to be at home
we meet and social with other people
to.

Jack G. Gantz
Bessie D. Gantz

Lassen Low Care
Gardena

To whom it may concern:

Since coming to the center, it really has changed my life. The meals have been great and it gives me more time to do other things and I dont have to be alone. I have made quite a few friends and have learned to do quite a few things since coming here.

All the people here are very helpful at all times and I like all of the workers, they are allways ready to help when they can. I have learned quite a few things since coming here and we are allways learning something new.

I am glad I heard of this place because it has taught me how to do a lot of things

Edna M Wollenhaupt

PARTICIPANT

Town Day Care Center
Feb 13, 1990

To whom it may concern:

I like to express my appreciation for this care center. This is where I spend most of the day and really love. It helped me to cope with my depression.

The staff from top to bottom has been very kind to me and I've had an opportunity to socialize with the others that like me are loners. It sure has made a big difference in my life style. I feel I am living again.

Thanks to all who made this possible for me.

Thanks again.

Miguelina Gonzalez

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

St Petersburg Fla 33

Dear day care center. Because the people are so nice to me. every one helps me out. I love money Friends at the center Socializing with others really make my day I like to come to day care & to be around people. Help & learn from them learn from one another.

Your Truly Mary Jordan

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

I love D Centerville because the People are nice to me and I feel at home

Fred Looker

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

Feb. 12, 1990

Day Care

I like the Day care Class because I can't get that subject taught at my home here I was hoping to be able to do the work and maybe able to teach the subject to the younger Children and they will be able to use it in the near future. Our adult years have not taught us and yet we can use.

That is the reason for me being here I am sure it will help me and others I am able to teach. I have - I need to learn subject better than I do at this present so I will know a great deal more then I did. Hope I'm right

Sincerely
Margaret Tyler

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

Feb 12, 1990

I like coming to Day Care to be a part of people and not living lonesome at home every one is nice here thank God for the day Come Chr home

Fred Small

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

February 12, 1980

Why I like Day Care.

I like the Center, because it provides me with Companionship, food and Medical assistance. We have lots of nice people To assist you in Whatever you attempt.

Sign
Major Hooks

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

Feb. 12, 1990

The Day Care is very important to me because I am a very sick person I feel very safe at the day care there are always some one around you. its like a family there. I enjoy Craft, painting, coloring. most of all the sewing class. the staff are very friendly & Helpful. the day care is helpful in many ways. it's Asst. us to the Dr, shopping, make sure we eat the right foods. we have a nurse at the day care. I want the Day care to always to be here for me.

Juanita Grand

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

Feb 12, 1990

Day Care is very important to me. Being at the Day care is very much a happy place to be. No Elderly person needs to be at home a lone. At the Day care you can meet friend do different Arts & Craft work. A day care to me is like a home. I just don't know what we would do without the day care. the staff Asst us with our Dr's appointments & grocery shopping. the staff are very friendly and Helpful. they pick you up when you're feeling low. if day care were not here some of us would not make it at all.

Elizabeth Monroe

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

Feb. 12, 1990

The Staff at the Day Care Center are very helpful to the Elderly. They help the elderly to cope with life at an Older Age. Day Care staff helps us make our Dr's Appointment see that we shop for grocery. When we are ill the Day care Nurse is there to check us also make calls to Dr is need be. staying at home during the day alone is not very good for Elderly People We may not be able to get to a phone when we feel ill At the care Center the staff & nurse get to know you they can tell if you are feeling bad. I Love Day Care don't know what I would do with out it.

Margaret Daughtry.

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

William C. Bobb

well the next thing I like about this is season is, you see it gets really ~~too 600~~ sad sometime bein home, alone, and I like think that this place really replaced the fact of being alone.

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

PARTICIPANT

I like the day care center because
i would like to stay at home a long.
like the staff at the center
they assist me in my needs.
i like to dress to all so to looking
i like to make cake and pie

Yours truly

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

Dec. 14.

Today class is on part to
Do self care. I may self to date and I
forgot my pain medicine, I can't
get any help for it
May
Margaret Hardison

Town Adult Day Care
Bethel Community Baptist Church
1045 - 16th Street South
St. Petersburg, FL 33705
823-2019

[illegible]

[illegible] my thoughts [illegible]
[illegible] I [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible]
there.

My big regret is, that I didn't start [redacted] three or four years, before I did.

I am always glad when Morning comes, I know I will enjoy another day, each one passes so quickly it is time to go before I am near ready.

I love doing any of the Hand works and am always glad to see the days come when we have Bingo, they are my favorite things.

Nothing has worked as great as it is with out the wonderful staff, they are what keeps us going and so very happy to be there.

It has been special days that I will cherish over Xmas.

To you From my thanks your great [illegible] have been so good and wonderful to me during my visits I can't express the [illegible] I have tried.

Love my love,
Always a friend

CAREGIVER

2.24.90

Palm Harbor Day Care
Attn: Liz Kelly

Dear Ms Kelly:

I am writing this letter to stress the importance of the Day Care Center to my brother Cecil.

As you know Cecil suffers from Parkinsons disease and the Center is his only chance of being with people his own age and in circumstances similar to his. Each day Cecil gets dressed and sits in the chair, looking out the window waiting for the bus to take him to the center. It is his only outlet for being in touch with other people. Since I work during the week, it would be impossible to be with him, but what a relief for me to know that he is under supervision and care and getting the medication he needs daily.

I cannot express my sincere appreciation enough to the personnel of the Palm Harbor Day Care Center for the care and supervision that they are giving him and hope it will be continued in the future

Sincerely,

Cecil's

CAREGIVER

452 Wildwood Lane Blvd
Palm Harbor, FL 34683
Feb 22, 1990

Dear Mr. Keirn,

My mother is 89 years of age & required constant attention. The Palm Harbor Adult Day Care Center offers my mother & respite from an attentive monitoring system. and gives me a release from the constant care & stress. Without this capable help and loving care, I don't believe I could continue to care for my mother at home.

Sincerely,
Kathy Shaw

CAREGIVER

I want to express my appreciation for Respite Senior Service program. This respite program is truly a blessing for the caregiver & the people who take charge at the Palm Harbor are very much caring group, giving all seniors individual attention to make them comfortable while they do enjoy the day.

Thank you for Abraham

Mrs. Helen M. Hott

CAREGIVER

The Neighborly Senior Center keeps my husband's mind active. He reviews newspapers. The Center keeps his mind stimulating. He does follow-through with the program at the Center.

It gives me the opportunity to take care of my own problems like dental and medical.

It's a good emotional outlet for me for I am responsible for his total care the remaining hrs of the day.

It's a mental stimulus for Dan to be able to go somewhere without me, in that it gives him conversation and something to talk about.

Mrs. Lenna Ewing

Honorable Mrs. Kean,

I'm writing this letter in support to the Adult Care Center in Palm Harbor. I have been taking my sister Shirley Bradburn there for about two years now, and believe me it is sure nice to have someone you can trust and rely on to have a break a couple of times a week.

We pay what we can and we know it isn't enough, she was getting a supplement, but a year ago last Christmas our Father passed away and they took it away from her. I recently received a letter from H.R.S. saying that anyone getting less than $700.00 is entitled to the supplement but I haven't had time to go and see about it. I also have our mother in a nursing home will be 89 in April. Shirley is 62 and she has the mentally retarded mind of one year old from brain damage due to a fall.

So we've all taken part in caring for her to keep her out of a nursing home.

Anything that you can do to help this Center in its operation and the good help they have there will be greatly appreciated.

Thank you for your support.

Sincerely,

Mr. + Mrs. William Corbin

for Shirley Bradburn

PARTICITANT
CAREGIVER

Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

February 27, 1990

Neighborly Senior Services, INC.
13650 Stoneybrook Drive
Clearwater, Florida 34622

Dear Liz,

My husband and I are the primary caregivers to my Mother. The Neighborly Senior Center Adult Day Care service affords us two days of respite. "Mr. Webster" defines respite as an interval of rest or relief. How true.....it is time.....time to go to the bank, a store, visit a friend, have lunch out, read a book, color your hair, go to the beach or just do absolutly nothing at all.

The Day Care service offers my Mother an environment suitable for socializing.....she is mentally and physically stimulated.....and is in a caring environment.

As caregiving is a 24 hour a day job, the supervised Day Care is a very, very special service to each of us. Our thanks to the Neighborly Senior Services.

Sincerely,

Jean and Bill

Jean and Bill Warren

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To Gloria Senior Service has been a God send for my mother and family.

Both my husband and I are retired and still have a 15 year old daughter at home.

My mother has been in my care 4 yrs. Seeing her going into a world of her own, seemed just giving up on life. This is a hard thing for anyone to face. The doctor recommended, Pinhorn Senior Service highly for her.

We have seen her more alert and a happier person after coming from her 6 hr visit there. She enjoys being with her new friends.

The people attending all the senior citizens in my mothers situation, are very dedicated trying to put up all kinds of activities. It keeps them from going into a shell. And the location is perfect since there also is a child day care center next door. It helps young children to love and respect the elderly. In the same case the elderly love watching children at play.

There should be more centers like this. I do pray our community and legislative system will continue to support the Adult Day Care, and get more government assistance to keep such a program going.

This program has helped my mother, and it has given me a break, to have a few hours for myself and the rest of family.

Mrs Commander

3/23/90

Dear Senator Bob Kasser

Attending Day Care for my father in law has been a very positive point for him. Since the death of his wife he has been living in an Assc home. He was depressed. The people were very nice and he is well taken care of but there wasn't enough to stimulate his mind. All he wanted to do was sit and smoke cigarettes.

Since he has been going to Senior Citizen 5 days a week he is a new person. He is dancing, playing Bingo, exercising and socializing with other people. On his former visit we are thrilled to know. Carries on conversations and can even remember about the cruise we went on. They study.

I hope you can see the need for Senior Citizen Adult Care for the elderly.

The elderly are very precious. We provide day care for our young people. We need it for our elderly. They are just as important.

Thank you very much

Mary Jo Riley
624 Rock Ct
Palm Harbor, Fla
34683

CAREGIVER
Palm Harbor Area
Palm Day Care
1550 - 16th Street
Palm Harbor, FL 34683
784-0680

3/5/90

Chairman Downey,

Congressman Bilirakis

The House Select Committee on Aging

The Subcommitee on Human Services

This is 1990, I sure don't need to remind you all of that fact. This is the start of a new decade and yet it is the last decade of a 90 year old century. The twentieth century and our elderly population of Pinellas County have that older age in common. The graying years have now turned white. The old grow older and the needs of caring programs increase. The kinds of care have escalated to be more serious and more demanding for the older old who are nov over 85, 90 and 100. These participants today are more frail, more fragile and in need of more personal care, medical care and nursing assistance than ever before.

We, the Aging Programs in Pinellas County, need the House Select Committee and the Subcommittee on Human Services to assist in every way possible to encourage the legislators to enact the laws that will assist those who have the greatest needs. The Older American Act needs more Adult Day Care dollars and it needs to assist the state with Community Care for the Elderly.

In our Adult Day Care programs 75% of the participants are over 75, 40% of those are over 85 and 36% of those are over 90 years of age. Four, who are presently in the program, are over 100 years of age.

There is a vital need here in Florida for funding of programs for our older citizens. From 1950 through 1980 our 60+ population doubled in the U.S.A.

This same kind of doubling will happen by 2010. Florida and Pinellas County faces the most need of anywhere in the world for funding to support the needs of these older older.

Your support is vital to be able to meet the demands of this "aging" population in Pinellas County and all over the State of Florida. Move us into the last decade of this twentieth century with programs that are funded to provide the services in the amounts necessary to meet the demands of this aging population.

I see increased demands each day as I direct the Adult Day Care Project for Neighborly Senior Services, Inc. here in Pinellas County, Florida.

The Elderly are waiting, don't lock them out!

Thank you.

P. Dale Sklenar

Project Director of Adult Day Care

for Neighborly Senior Services, Inc.